FTF Internal Audit Service

Internal Audit Annual Report 2024/25

Report No. A10/26

Issued To: **R McGuffie, Chief Executive**
S Urquhart, Director of Finance
NHS Forth Valley Senior Leadership Team

K Mackenzie, Acting Director of Strategic Planning and Performance
J Frawley, Board Secretary

Audit & Risk Committee
External Audit

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Draft Report Issued	4 June 2025
Management Responses Received	10 June 2025
Target Audit & Risk Committee Date	17 June 2025
Final Report Issued	**10 June 2025**

INTRODUCTION AND CONCLUSION

1. This Annual Report to the Audit & Risk Committee provides details on the outcomes of the 2024/25 internal audit and my opinion on the Board's internal control framework for the financial year 2024/25.

2. Based on work undertaken throughout the year I have concluded that:

- The Board has adequate and effective governance, risk management and internal control arrangements in place.
- The 2024/25 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, I have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work.
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected.
- The format and content of the Governance Statement in relation to the relevant guidance.
- The disclosure of all relevant issues.

ACTION

4. The Audit & Risk Committee is asked to take **Reasonable Assurance** from this report in evaluating the internal control environment and report accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2024/25 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance and were approved by the Audit & Risk Committee. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 15.3 of the Board's Standing Financial Instructions.

7. Internal Audit is also required to provide the Audit & Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

Previous recommendations

8. As well as following up previously agreed actions, we have completed testing to identify any material changes to the control environment in the period from the issue of the 2024/25 Internal Control Evaluation (ICE) to the year-end. Areas for further development were identified and will be followed up in the 2025/26 ICE.

9. The remaining actions to address recommendations in our previous ICE and Annual Reports, along with an assessment of progress are included in Section 5.

10. NHS Forth Valley has demonstrated good progress towards completion of previous recommendations, with some extended to take account of changing plans and some not yet due.

11. The 2025/26 ICE will provide an update on the remaining actions as well as providing an opinion on the effectiveness of implementation of all agreed actions.

Governance Statement

12. Throughout the year, our audits have provided assurance and made recommendations for improvements. Where applicable, our detailed findings have been included in the NHS Forth Valley 2024/25 Governance Statement.

13. For 2024/25, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as a whole, which would therefore include activities under the direction of Integration Joint Boards (IJBs).

14. The Board has produced a Governance Statement which states that:

- *During the 2024/25 financial year, no significant control weaknesses or issues have arisen, and no significant failures have arisen in the expected standards for good governance, risk management and control. Attention is, however, drawn to the key strategic risks reported to Forth Valley NHS Board during 2024/25 and in particular to the Treatment Time Guarantee underpinned by statute.*
- *As the appointed Accountable Officer, I am able to conclude with the ongoing improvement work undertaken throughout the year, as evidenced above; the governance framework and the assurances and evidence received from the Board's committees, that corporate governance continues to be strengthened and internal controls were operating adequately and effectively throughout the financial year ended 31st March 2025.*

15. Our audit work has provided evidence on the adequacy and effectiveness of the corporate governance framework in place within the Board throughout 2024/25 and provides assurance for the Chief Executive as Accountable Officer.

16. Therefore, **it is my opinion** that:

    - The Board has adequate and effective governance, risk management and internal control arrangements in place.
    - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

17. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility, with each completing an Internal Control Checklist based on the Scottish Public Finance Manual. These assurances have been reviewed and no breaches of Standing Orders / Standing Financial Instructions were identified.

18. The Governance Statement reflects the Board governance and operating arrangements. It includes details of the Board performance profile and risk management arrangements, and organisational and supporting strategies. All elements of the Governance Statement have been considered by Internal Audit and no material omissions have been identified.

Key Themes identified from fieldwork were:

19. On 1 October 2024 the Board was moved from Stage 4 to Stage 3 in the Scottish Government Performance Escalation Framework. The work that continued across the whole system to elicit sustainable and ongoing improvements was detailed in the Escalation Assurance Report presented to Board on 27 May 2025. A portfolio of evidence will be submitted to the Scottish Government to demonstrate further evidence of improvement at Stage 3. Work has progressed system wide to ensure improvements made have been sustained as business as usual. Work to strengthen performance in respect of Leadership, Culture and Governance will continue.

20. The NHS Scotland Executive Group first met in October 2024 and plays a central role in supporting national and regional planning initiatives, providing collective leadership in addressing key issues which require a national perspective.

21. DL(2024)31: A renewed approach to population-based planning across NHSScotland was published on 28 November 2024 and set out the need for service planning to align with the population size and be collaborative. The shift in how services will be planned and delivered was further emphasised by the letter from the Director General Health and Social Care and Chief Executive of NHS Scotland on 7 February 2025, which set out the expectation for increased collaboration between NHS Boards to help improve health and wellbeing. This includes sharing resources, expertise and services.

22. The requirements from the NHS Scotland Executive Group on collaboration were endorsed at a special meeting of the Forth Valley NHS Board on 29 April 2025. Internal Audit note that there may be a risk associated with this and the Board may need to carefully balance local plans and responsibilities with national activity with a delivery timeline.

23. The Board's involvement in this national activity has the potential to support sustainability. There are several areas where NHS Forth Valley has collaborated with partner organisations and regionally to improve service delivery. These are highlighted in the corporate governance section of this report.

24. Corporate objectives make a key connection between the performance framework, strategic goals and risk, allowing system wide alignment of priorities for 2025/26 and providing a mechanism to hold senior officers to account for delivery of the most important actions. While appropriate corporate objectives for 2024/25 were approved by the Board there has been no outcome reporting on these. Corporate objectives for 2025/26 have been approved, aligned with the Board's Delivery Plan, and we would expect progress to be monitored in 2025/26.

25. NHS Forth Valley has demonstrated commitment to cultural improvement work, as evidenced through the progress with the Culture Change & Compassionate Leadership programme. Leaders have the most significant opportunity to influence culture and it is important that the executive team continues to cultivate a culture that promotes transformation and reform. Successful reform will require the 'right' culture to shape how staff perceive the importance of change and continuous improvement, and how they engage to deliver the draft Population Health and Care Strategy 2025 – 2035. The Strategy is out for consultation and is scheduled to be presented to Board for final approval by end of September 2025.

26. On 27 January 2025, the First Minister described plans to renew the health service and deliver the change in Scotland. The first component of this is the Operational Improvement Plan, to be followed by publication of a population health framework and a health and social care service renewal framework. Together these plans are intended to progress reform to ensure long-term sustainability, reduce health inequalities, further harness the benefits of digital technology, and improve population health outcomes in Scotland. They will set out how services will be planned for the whole population over the short, medium and longer term.

27. Audit Scotland's NHS in Scotland: Spotlight on Governance report, issued in May 2025, highlighted that Boards need to consider how change and reform sits within the overall governance system, so that there is effective and sufficient senior scrutiny of not only day-to-day operational and financial delivery but also of plans and progress on reform programmes. The report also commented that '*Good scrutiny and setting a clear direction are essential functions of NHS Boards. Boards are making use of the Blueprint for Good Governance to develop their governance arrangements. There is more work for Boards to do in setting a clear direction and working with others to deliver reform and work towards a sustainable future'*.

28. Governance arrangements have continued to evolve and improve during 2024/25. Internal Audit has met with the Chair, Chief Executive, the Acting Director of Strategic Planning and Performance and the Board Secretary to explore the direction of travel for NHS Forth Valley governance arrangements, including the role of the Strategic Planning, Performance & Resource Committee (SPPRC).

29. The SPPRC has a focus on embedding further good governance based on optimal flow of assurances, to ensure their agenda is focused on key risks and issues.

30. In the corporate governance section of this report we have commented on the extensive SPPRC agenda and the high number of risks currently aligned to the SPPRC.

31. At the December 2024 Board Seminar, it was agreed that levels of assurance would not be provided within Board and Standing Committee Assurance reports. Review and benchmarking of the cover paper template is ongoing. Internal Audit has previously reported that the provision of a level of assurance supports focus of key risks, helps drive scrutiny and challenge, and papers and Board and Committee minutes should state the level of assurance agreed and any relevant discussion and recording of decisions. Any future system of assurance should be formally evaluated. We would anticipate that NHS Forth Valley will take cognisance of the 'Spotlight on Governance report' to support the governance framework and drive reform.

32. Risk management systems and processes continue to evolve. The alignment of strategic risks to Standing Committees is ongoing, and work is also in progress to ensure appropriate oversight of organisational risk. In each governance section of this report we have commented on the relevant strategic risks.

33. In common with other Health Boards, performance at the end of January 2025 against national targets was variable and challenging in some areas. Reflecting the complexities in delivery against targets we welcome the SPPRC focus on key issues in relation to performance.

34. The Clinical Governance Committee (CGC) has an extensive remit, with Terms of Reference and the 2025/26 planner undergoing an in-depth review. In the clinical governance section of this report we have highlighted and discussed two significant findings for Management consideration.

35. Value Based Healthcare aims to make the best use of the resources available, to improve the health of all local people, achieve better outcomes for patients and deliver sustainable health services. Following on from work to raise awareness of this area, workstreams are being established to support implementation of a new Value Based Health and Care Programme.

36. We have observed improvement in the operation of the Staff Governance Committee (SGC) compared to 2023/24. The appointment to the substantive post of Director of People has provided leadership and focus, we would however emphasise the importance of maintaining progress in this area and that the well documented workforce risks remain across NHSScotland.

37. The draft financial outturn position to 31 March 2025, subject to external audit review, is a £0.239 million underspend against the Revenue Resource Limit (RRL) of £953.9 million

38. However, non-recurring sources of improvement, for example, additional Scottish Government funding, do not contribute to future financial sustainability. The need for sustainable cost improvement and enhanced financial controls to support a path to recurring financial balance will continue to be necessary.

39. Delivering required savings is vital in laying the foundations for future financial sustainability. Work on grip and control must continue to be progressed at pace to ensure that an outturn position within the level of Scottish Government agreed financial support and recurring savings are achieved for 2025/26 and onwards.

40. Audit Scotland's IJB Finance Bulletin 2024/25, issued in March 2025, stated that "*IJBs finances continue to be precarious. IJB's 2023/24 funding has increased in real terms compared to 2022/23 but there is a concerning picture of continued overspending, depletion of reserves and required savings being met through one-off, rather than recurring savings*". Internal Audit have previously reported similar concerns and the financial risk environment for the Falkirk and Clackmannanshire and Stirling IJBs and the partner organisations continues to increase.

41. The IJB Finance Bulletin 2024/25 also made clear that the growing gap between the capacity and funding, and the demands being presented, created an escalating risk to the collective ability for IJBs to deliver and commission services. Generally, the availability of IJBs' contingency reserves is diminishing, which may result in the need to rely on each IJB's Integration Scheme with the possibility of additional contributions from partners to address unfunded cost pressures.

42. The financial and service challenge across health and social care remain and as previously reported by Internal Audit, NHS Forth Valley, local Councils, the IJBs and wider partnership will need to work collaboratively to ensure that they deliver on the integration agenda in line with the Integration Schemes. This includes ensuring there is cohesion across the health and care system to help inform and shape transformation plans.

43. NHS Forth Valley Board approved the revised Integration Schemes for both Falkirk and Clackmannanshire & Stirling IJBs on 28 January 2025. The Falkirk Integration Scheme has been approved by all relevant parties and has been submitted to Scottish Government for Ministerial approval, however the Clackmannanshire and Stirling Integration Scheme has still to be approved by Clackmannanshire Council. Both Stirling and Clackmannanshire Councils have initiated the dispute resolution process in a bid to resolve outstanding issues with the scheme. The most extensive revisions to the existing schemes (dated 2018) were in the finance section, in a bid to strengthen and improve the level of detail provided on financial governance and financial management, including risk sharing arrangements.

44. As financial resources, including capital, are put under increasing pressure the benefits from reductions in energy consumption and moving towards sustainable healthcare are clear. However, meeting the challenging targets also requires investment and resourcing and the Board need to be assured that measures taken will ultimately benefit NHS Forth Valley and its service users. Limitations in available funding may make it increasingly challenging to make progress in this area.

45. While the Information Governance Annual Report 2024 provided Reasonable Assurance, it did report the move from level 1 to level 3 of the Scottish Information Commissioner intervention, in relation to Freedom of Information requests. This area is being rigorously and methodically monitored, both internally, and externally by the Scottish Information Commissioner. NHS Forth Valley has performed well in compliance with Network & Information Systems Regulations.

46. We have identified required improvement in provision of assurance on delivery of the Digital & eHealth Delivery Plan.

47. Key findings emerging from this review and other audit work during the year are detailed within each Governance section, which also details, for context, relevant Strategic Risks.

48. Key developments since the issue of the 2024/25 ICE included:

- Further strengthening of the leadership structures through the guidance of the Chief Executive.
- Approval of 2025/26 Corporate Objectives.
- Draft Delivery Plan 2025/2026 submitted to the Scottish Government.
- Board approval of Blueprint for Good Governance Development Plan 2024/25 outcomes and the 2025/26 Plan.
- Board approval of draft Population Health and Care Strategy 2025-2035 and its Strategy Communications and Engagement Plan.
- Ongoing work to refresh and embed governance arrangements.
- Approval of Board Assurance Framework.
- Improvements in Remuneration Committee governance.
- Board approval of Financial Plan 2025/26-2027/28.
- Culture Change & Compassionate Leadership programme in progress.
- Staff Governance Committee approval of the Annual Safe Staffing Report 2025.
- Board approval of the Equality and Inclusion Strategy 2025-2029.
- 90% compliance reported in the Network and Information Systems (NIS) 2024/25 progress review.

Audit Output

49. During 2024/25 we delivered 23 audit products. Work is progressing on the two remaining reviews, with the remaining reports to be presented to the 31 October Audit & Risk Committee meeting.

50. Our 2024/25 audits provided assurance on the adequacy of governance, risk management and controls. Summarised findings or the full report for each review were presented to the Audit & Risk Committee throughout the year.

51. A number of our reports, including the ICE, have been wide ranging and complex audits and have relevance to a wide range of areas within NHS Forth Valley.

52. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of governance, risk management and control.

ADDED VALUE

53. The Internal Audit Service has been responsive to the needs of the Board and has assisted the Board and added value by:

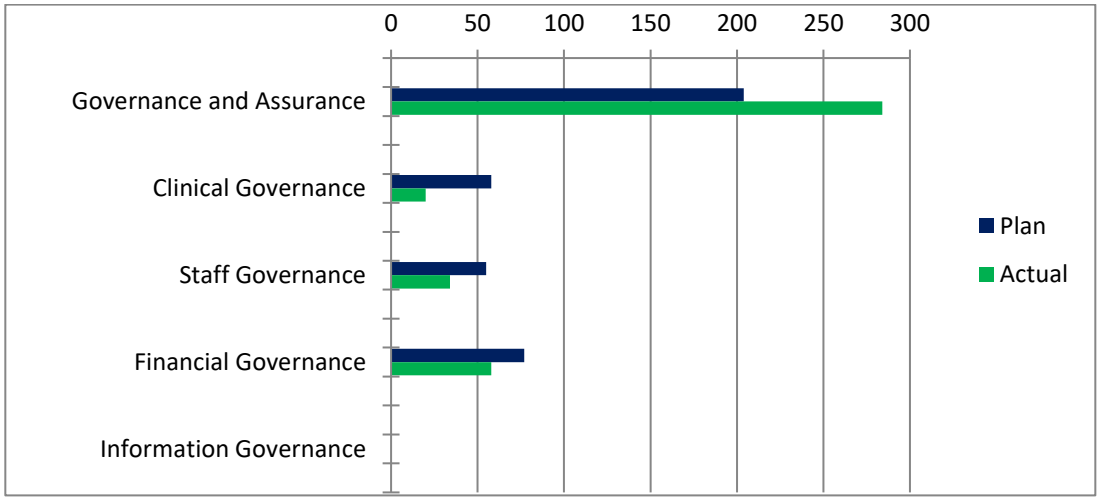
- Examining a wide range of controls in place across the organisation.
- Audit Follow Up validation and associated reporting and assurance to the Audit & Risk Committee.
- Chief Internal Auditor and Regional Audit Manager liaison with the Chief Executive, Chair, Director of Finance, Directors, and the Falkirk IJB Chief Finance Officer on issues of governance, risk, control, and assurance.
- Continued promotion and advice on the use of the Committee Assurance Principles.
- Provision of the Fraud Liaison Officer function for NHS Forth Valley.
- Undertaking IJB internal audit and providing the Chief Internal Auditor Service for Falkirk IJB.

54. Internal Audit has in place an Improvement Action Plan to ensure compliance with the Global Internal Audit Standards (GIAS), the UK Application Note: GIAS in the UK Public Sector and the External Quality Assessment of Internal Audit, published on 4 March 2025.

55. The 2024/25 Annual Internal Audit Plan included provision for delivering audit services and providing the Chief Internal Auditor function to Falkirk IJB, with the Internal Audit Plan agreed. Internal Audit has continued to highlight the requirement for coherence between governance structures, performance management, risk management and, in particular, assurance to improve the ability of the IJB to monitor the achievement of operational and strategic objectives.

INTERNAL AUDIT COVER

56. Figure 1: Internal Audit Cover 2024/25



57. Figure 1 summarises the 2024/25 outturn position against the agreed Internal Audit Plan for standalone audits. The Annual Internal Audit Plan was approved by the Audit & Risk Committee at its meeting on 25 October 2024. As at end of April 2025 we had delivered 397 days against the 394 planned days. There are currently two Health Board and two IJB reviews in progress. Sufficient Internal Audit assurance has been provided to inform the Chief Internal Auditor's opinion.

58. A summary of 2024/25 performance is shown in Section 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND INTERNAL AUDIT STANDARDS

59. The FTF Partnership Board met in line with their Terms of Reference in 2024/25. The Partnership Board was chaired by the NHS Fife Director of Finance and Strategy and the FTF Client Directors of Finance are members and the NHS Forth Valley Director of Finance became the Chair from April 2025. The FTF Management Team members are attendees. The Partnership Board Annual Assurance Report concluded that *'As the new Chair of the Partnership Board from 1 April 2025 and as a member of the Partnership Board during 2024/25, I can confirm that the breadth of the business undertaken, and the range of attendees at meetings of the Partnership Board has allowed us to adequately and effectively fulfil our remit'.*

60. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the requirements of PSIAS, whilst also working towards compliance with the new Global Internal Audit Standards (GIAS).

61. Internal Audit is compliant with the PSIAS relevant for the 2024/25 audit, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

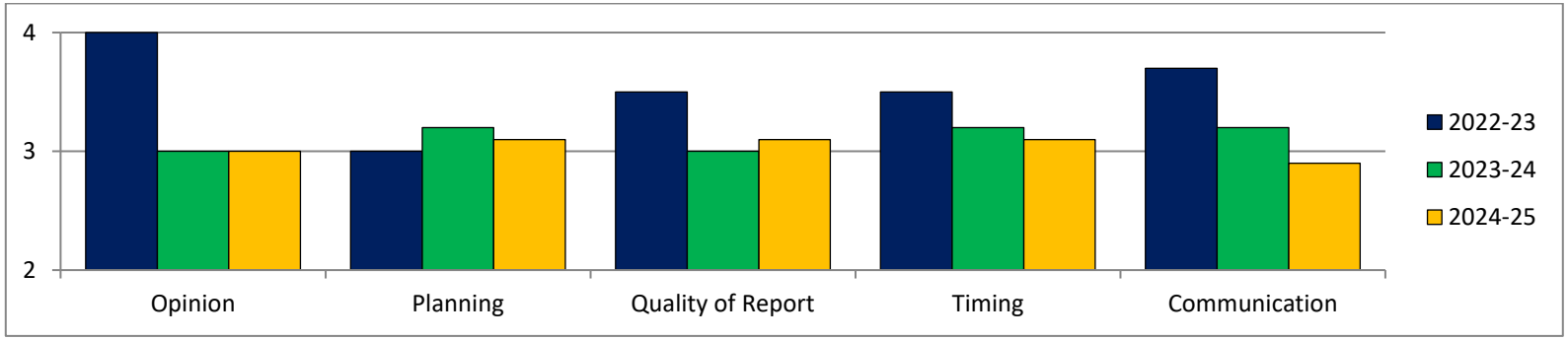
62. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

63. PSIAS required an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Forth Valley Internal Audit Service published on 4 March 2025 concluded that, '*Our overall opinion is the internal audit services provided by the FTF internal audit function and NHS Lanarkshire's internal audit function generally conform to the PSIAS*'.' 'Generally Conforms' is the highest level of attainment.

64. A key measure of the quality and effectiveness of the audits is the Board responses to our Quality Questionnaires, which are sent to Responsible Officers following the issue of each audit report. Figure 2 shows that, overall, our audits have been assessed as generally good by the report recipients.

65. Figure 2: Summary of Quality Questionnaires

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



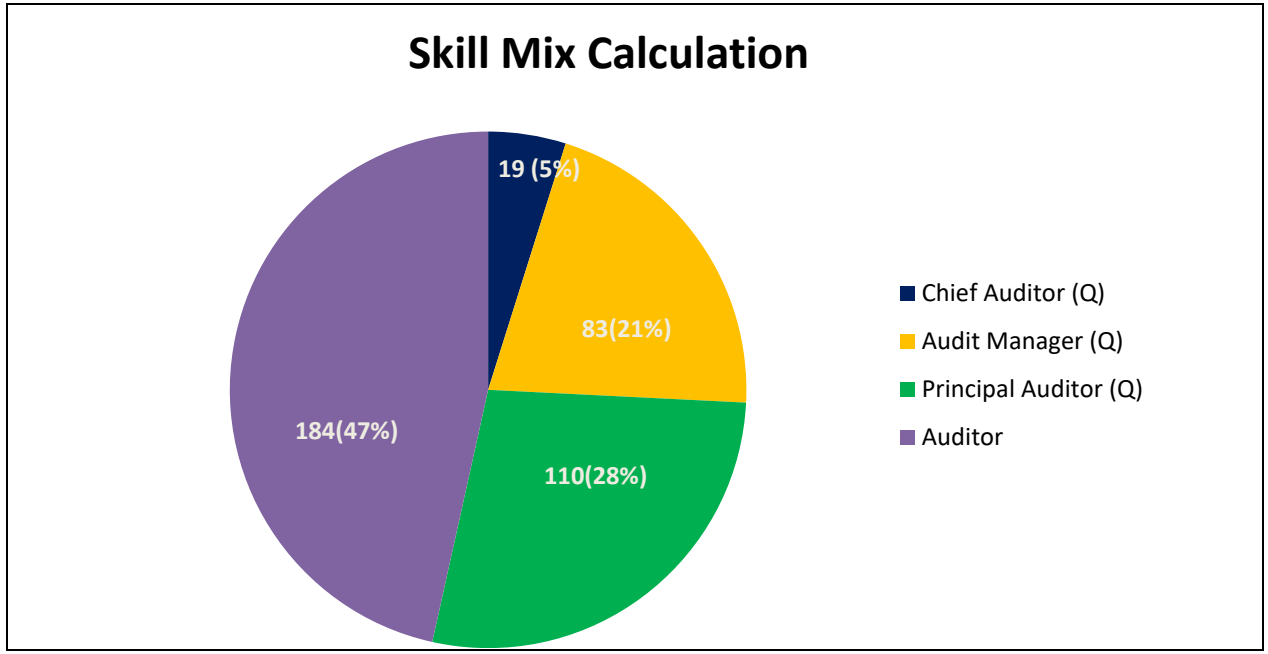
66. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

67. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2024/25 Internal Audit delivered a qualified skill mix of 54%, which exceeds the service specification requirement of 50% qualified input.

68. **Figure 3: Audit Staff Skill Mix 2024/25**

Audit Staff Inputs in 2024/25[days] Q= qualified input.



ACKNOWLEDGEMENT

69. On behalf of the Internal Audit Service, I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

70. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Acting Director of Strategic Planning and Performance, and wider SLT, the Board Secretary and the Audit & Risk Committee.

Jocelyn Lyall, BAcc (Hons), CPFA
Chief Internal Auditor

Corporate Governance

Strategic Risks:

SRR020: Health Inequalities: Current score: 20 (Very High), Target score: 10 (Low)

If NHS Forth Valley does not work with partners to influence the social determinants of health and the NHS does not create a healthcare system which can be accessed by all the people of Forth Valley, there is a risk that health outcomes do not improve, and health inequalities do not reduce or may even widen. This could result in reduced healthy life expectancy for the population, or for individual population groups, and a significant financial cost through increased need and demands on services.

Leadership and Culture

A comprehensive update on all aspects of the Assurance and Improvement Plan, including the Culture Change & Compassionate Leadership (CC&CL) Programme, was presented to the Board in May 2025. The Board agreed the content and requested the addition of Remuneration Committee evidence of culture change, and information that further work would continue to be undertaken to develop culture measures.

During December 2024 and January 2025, four of the eight CC&CL Programme projects completed their mobilisation process. The four Phase 2 projects completed their initial mobilisation on 8 May 2025 and should complete the second part of the process on 24 June 2025.

The CC&CL Programme Board continues to review two issues that need to be overcome: (1) historic organisational issues in communications with HSCP colleagues and partners, and (2) Improving engagement with easy-to-miss staff groups using targeted communications.

In our 2024/25 ICE we reported that during the year there were a number of changes within the senior team, including interim and acting appointments within NHS Forth Valley and the IJBs. We have observed further strengthening of the leadership structures as the Senior Leadership Team becomes more established.

'On Board – A Guide for Members of Statutory Boards' (January 2023), published by Scottish Government notes "*The Chair has additional responsibilities over and above those of Board members, particularly in relation to leadership, the conduct of Board business……."* In our opinion, there is evidence to demonstrate that the interim Board Chair is delivering against this expectation.

The Board Chair's review of non-executive portfolios was reported to the September 2024 Board, with changes implemented from 1 February 2025. Three new Non-Executive Directors have been recruited and induction has commenced, with formal start dates to be confirmed. The induction programme was reviewed in April 2025 and now includes locally delivered induction training highlighting the range of training material provided by NHS Education for Scotland, a 'buddy' scheme for new non-executive members and newsletters / documents of interest distribution by way of a regular Board Round Up.

The recruitment process for a permanent Board Chair has commenced to replace the Interim Chair whose term of office is scheduled to end in September 2025.

Corporate Objectives

Corporate objectives for 2024/25 were approved in principle by ELT on 20 May 2024 and approved by the Board on 30 July 2024. They were aligned to Delivery Plan and were related to: Leadership; Culture; Governance; Transformational Change; Financial; and Performance. There has been no overarching summarised reporting, e.g. one-page RAG assessment, on progress against 2024/25 corporate objectives.

The Corporate Plan, which included the vision and corporate objectives for 2025/26, was approved by the Board in March 2025. The corporate objectives are aligned with the Board's Delivery Plan and comprise Collaboration; Transformation; Stewardship; and Outcomes.

In March 2025, Board members were apprised of how corporate objectives inform performance objectives throughout the organisation using the Pentana system which will also provide assurance information. The Director of People has advised Internal Audit that an Executive Team Development Session took place in April 2025 to commence the process of objective setting for 2025/26. The sign-off of Executive Objectives is intended to create a 'golden thread' from the corporate objectives, through the agreed in-year deliverables, to the Executive's objectives.

To ensure that the Board's vision and corporate objectives are seen throughout the organisation and by the public, communications to staff are to be issued, along with publication of information on the public website.

Governance Arrangements (including Blueprint for Good Governance and Development Sessions)

The Board's Blueprint for Good Governance Development Plan 2024/25 was reviewed in March 2025, noting significant progress with a number of actions closed. The Board approved the 2024/25 outcome and the 2025/26 Development Plan. Actions carried over to the 2025/26 Development Plan are:

- Equality, Diversity and Inclusion
- Active Governance – data and triangulation
- Review of the Board's management of risk – including risk appetite and risk tolerance
- Influencing Culture – work to evaluate the CC&CLP.

A Board Seminar on Active Governance took place in December 2024, facilitated by National Education Scotland, and provided learning to inform the work of the Board in preparing an assurance framework. Using the model set out in the Blueprint for Good Governance, and guidance from the Good Governance Institute, a Board Assurance Framework (BAF) was approved in March 2025. It is noted this is an iterative document and will be updated as required, for example to reflect the outputs of the revision of the Risk Management Strategy, including risk appetite and tolerance statements, which is currently scheduled to come to a Board Seminar in October 2025 ahead of formal approval by the Board.

At the December 2024 Board Seminar, it was agreed that levels of assurance would not be provided within Board and Standing Committee Assurance reports. This decision was reached following discussion on how the assurance provided was being

misinterpreted and there was variation in practice, in terms of what precisely assurance was provided on, and on whether assurance provided was absolute in terms of 'assured or not'. The Chair advised that the review of the cover paper template would seek to make the purpose of papers, the risks and mitigating actions, and their recommendations clearer. The Board Secretary indicated that benchmarking was taking place of the Board's template against model national guidance.

Internal Audit has previously reported our view that the provision of a level of assurance supports focus of key risks, helps drive scrutiny and challenge, and papers and Board and Committee minutes should state the level of assurance agreed and any relevant discussion and recording of decisions. While this remains our opinion, based on good practice, governance refers to the systems of control and direction within an organisation that aim to support it in delivering its strategic and financial objectives. If the current governance system is viewed as not achieving this goal, it is sensible to explore other options to identify a solution that meets the needs of the organisation.

The Code of Corporate Governance was reviewed and was approved by the Board in March 2025, following review by the Audit & Risk Committee. Standing Orders were revised to align more closely with the national Model Code and Committee Terms of Reference were revised in a new consistent format.

Board Development Sessions since the issue of our 2024/25 ICE have covered: understanding Value Based Health and Care; Board Members' responsibilities in relation to Equality, Diversity and Inclusion; and the financial plan. Non-Executive Directors have attended Governance Committee meetings in other Board areas to learn from and share practice. The Chair provides a verbal update on development sessions at the following Board meeting. Consideration should be given to introducing a brief formal update, which would provide further useful insight and transparently reports topics considered for development alongside the suite of Board papers.

A Board Seminar was held on 24 April 2025 in the form of a workshop on progress with escalation. Officers provided an updated position against the recommendations of the external review of governance (received October 2023). Board members had the opportunity to discuss progress and reflect on the improvements that had been made in governance. Overall, Board members agreed that there is enhanced clarity of roles, responsibilities and accountabilities, with improved flows of information, improved scrutiny and challenge, positive relationships and a culture of openness, with the NHS Board and SLT working effectively as a cohesive team with a shared purpose and vision.

It would be beneficial for the year end Committee Assurance Statements to contain an explicit reference to Best Value and confirmation that, within their relevant remits, the Committees can provide assurance that Best Value has been obtained in the year under review.

SPPRC

In our ICE 2024/25, management agreed that as part of the year end committee assurance process, an assessment would be undertaken to ensure the intended benefits from the creation of the SPPRC have been achieved.

As reported to the May 2025 Board, at a Board Seminar on 24 April 2025 feedback was taken from the SPPRC members around how the new Committee was functioning and if the desired outcome in terms of ensuring a space for strategic thinking was being achieved. The report notes the feedback was overwhelmingly positive in terms of providing the membership with the opportunity to shape and influence strategy

development. It was however noted that agendas were very full, acknowledging that only three SPPRC meetings had taken place to date, with the meeting structure continuing to evolve. It was highlighted that there was an improved alignment with, and flow into, the NHS Board.

The SPPRC is Chaired by the Board Chair, rather than another non-executive member. This has the potential to create a segregation of duties risk in that there may be less opportunity for the Board Chair to challenge and scrutinise the operation of the SPPRC than would normally be the case, where a Standing Committee is chaired by a different non-executive. This arrangement should be kept under review.

Good governance includes ensuring that there are no gaps and no duplication in reporting, and it is important that the SPPRC agendas are carefully managed to manage this. Recent assurance mapping work should be beneficial in this respect.

Whilst recognising the early benefits around the flow of business between the SPPRC and the Board we would recommend that ongoing work to realign risks from the SPPRC (10 of 12 strategic risks at May 2025) to other Standing Committees includes ensuring risks are aligned to the standing committee with the most relevant remit and professional expertise in the key aspects of each risk. We have commented further on this topic within the Clinical Governance Section of this report.

The risk realignment process to the SPPRC has in some instances lengthened the interval between planned focussed risk reviews. Transition of risks from the SPPRC should be carefully managed to minimise any detrimental impact on the transition timeline and the interval between the last focussed risk review.

Risk Management

The Corporate Risk Management Annual Report 2024/25 was approved by the Audit & Risk Committee on 28 March 2025. Following endorsement by the SPPRC in December 2024, the Board approved the closure of Strategic Risk SRR014 Healthcare Strategy in January 2025. The risk was incorporated into the new Health Inequalities risk (SRR020) which was approved in November 2024. Following significant progress implementing an improvement plan, the CGC endorsed the proposal to close Strategic Risk SRR016 Out of Hours Service in January 2025, the score having reduced to within the Board's appetite and tolerance level; prior to Board approval in January 2025.

Risks where scores have increased during the year are SRR011 (Digital and e-Health – Infrastructure and Strategy), SRR017 (Environmental Sustainability and Climate Change), and SRR019 (Culture and Leadership). The risk score for SRR018 (Primary Care Sustainability) has decreased during the year. Further comment on these risks is detailed in the relevant governance sections of this report.

The Risk Management Strategy 2022-2025 has been reviewed annually and is due to be refreshed and presented to a Board Seminar in October 2025, before progression to formal Board approval.

Risk appetite and risk tolerance levels for each of the impact categories on the risk assessment matrix, and associated appetite statements were approved by the Board in July 2023. Work has continued to enhance awareness and embed the framework into the organisation. Due to the changes on the National Risk Assessment Matrix, the review of this work was paused for 2024/25 and is on the Board's planner for November 2025. A review of the national risk assessment matrix was requested by Risk Managers across Scotland at the start of 2024, as part of the review of the Adverse Event Framework, and Health Boards across Scotland participated in this review. A short-life working group,

chaired by NHS Forth Valley's Corporate Risk Manager, progressed this work. The new national risk matrix was approved and published by Health Improvement Scotland (HIS) in March 2025 as part of the Adverse Event Framework. As noted above, an action carried over to the Blueprint for Good Governance Development Plan 2025/26 is a review of the Board's management of risk, including risk appetite and risk tolerance, with a final completion date of March 2026.

An Organisational Risk Register, which consists of cross-cutting risks that impact on, or require mitigating action from more than one directorate is also established. Work is ongoing to ensure appropriate oversight of Organisational Risk with regular reporting to the SLT and linkage to Strategic Risks where appropriate.

To further support and embed wider organisational connections, the Process, Risk & Assurance Group (PRAG), chaired by the Corporate Risk Manager, has recently been established. Primarily this group will identify challenges and propose solutions to the SLT, acting as an advisor where necessary.

Strategy Development, Planning and Implementation

In a Special Board Meeting on 29 April 2025 the Board approved the draft Population Health and Care Strategy 2025-2035, along with its Strategy Communications and Engagement Plan.

The Strategy was informed by engagement with service users, staff, and partner organisations and reflects both Falkirk and Clackmannanshire and Stirling HSCPs' Strategic Plans, national plans and policy. NHS Forth Valley's Interim Director of Public Health has been involved throughout the development of the national Population Health Strategy, ensuring alignment between these two plans.

A further period of engagement, as outlined in the Communications and Engagement Plan, is now in process, lasting from 1 May 2025 to 15 June 2025 after which the Strategy will be revised to take into consideration the engagement responses. An invitation to the public to have their say on the draft Strategy has a prominent place on the rolling 'banner' on the home page of the public website and it is featured on the home page of NHS Forth Valley's intranet, StaffNet.

The final Strategy will be presented to the Board for approval by the end of September 2025. The short life Task and Finish Group, whose membership includes several non-executives and is chaired by the Vice Chair of the Board, has provided input to the development of the Strategy, will continue to meet until it is approved by the Board, and published.

Internal audit A14/24 – Strategic Planning was issued on 5 August 2024 and provided Reasonable Assurance reflecting the significant strategy work completed to March 2024, in particular on engagement and culture. The report commented that the Strategy development process began in 2022, while acknowledging the ongoing developments in national population health strategy. Three recommendations were agreed on governance arrangements, the healthcare strategy risk and elements for inclusion in the Healthcare Strategy, with target completion dates of summer 2025.

At the Special Board Meeting in April 2025 the Board approved its new Equality and Inclusion Strategic Framework 2025-2029. The Framework demonstrates steps being taken to address inequalities and promote an inclusive environment across all levels of the

organisation. The NHS Forth Valley Anti-Racism Plan will align with the ongoing work of the Ethnic Diversity Network and the Equality and Inclusion Strategic Framework. Further detail on this is contained within the Staff Governance section of this report.

Collaboration

As noted in the Assurance & Improvement Plan update to the May 2025 Board, there has been a significant strengthening of input from NHS Forth Valley into the three Community Planning Partnerships (CPP) with the Chief Executive, Board Chair and Acting Director of Public Health attending these meetings. Through the Public Health department, progress is being made on developing outcome measures for the CPPs and identifying core priorities for delivery.

A new Forth Valley Leadership Forum has been arranged, with 2025/26 dates now confirmed. This will bring all public sector leaders together bi-annually to look at areas of collaboration in the Forth Valley area.

National Treatment Centre

An update was provided to the SPPRC on 29 April 2025 stating there are financial implications related to ongoing delays to the project's Practical Completion date, which will incur additional Technical Advisor, Legal Advisor, and insurance fees. The report notes that there is regular dialogue with Scottish Government infrastructure and finance leads who remain supportive of actions being taken to address outstanding issues. There are no anticipated additional costs to the Board for the rectification of defects. The timeline for ward completion and associated commissioning and handover processes is not confirmed and will require resolution of outstanding compliance issues as advised by NHS Scotland Assure.

Despite the construction delays experienced with the new ward, NHS Forth Valley continues to treat a significant number of patients from other NHS Boards with the support of the two additional operating theatres, MRI scanner, additional car parking, and funded workforce.

An update on this project has been scheduled into each meeting of the SPPRC in 2025/26.

Service Redesign / Transformation

During 2024/25 a key area of collaborative working has been around reducing the number of contingency beds in place across the Forth Valley system. The Forth Valley system has also joined the national Discharge Without Delay Collaborative. A whole-system Unscheduled Care and Delayed Discharge Plan has been developed but is now being updated to better reflect key elements of the Discharge Without Delay programme.

To further support reduction in the use of contingency beds, a business case has been developed to support the reduction of 32 beds through the creation of additional community capacity, working with the Falkirk HSCP.

One of the 2025/26 Corporate Objectives states '*We will reform and redesign the way we deliver health and care services to meet current and future challenges*' and follows from the 2024/25 'Transformational Change' objective. The 2024/25 Annual Report and Accounts within the Performance Report - Key Issues and Risks states '*It is clear that whole system transformation and reform is required to address longer*

term financial sustainability as part of the strategic direction for the future delivery of safe and effective health and care services within available resources.'

The direction of travel for the transformation agenda for the Board is captured within the Transformation objective deliverables, however, given the transformation and reform reflection in the 2024/25 Annual Report and Accounts, reporting on the success or otherwise against the Transformation Objective should be overt and clearly reported to the SPPRC whose remit includes scrutinising and overseeing the implementation of service redesign and transformation to ensure that the Board is sufficiently assured on progress with the transformation agenda and plan.

Anchor Programme

As reported in our ICE 2024/25, NHS Forth Valley and partners in the Forth Valley region agreed to pursue one regional Anchor institution, instead of four. The first meeting of the Shadow Regional Anchor Board was on 5 March 2025, with positive agreement to focus on a small number of 'pillars' as priorities. Task and Finish groups would be developed to support progress with buy-in from local partners.

The Delivery Plan 2025/26 contains an appendix with information and objectives in relation to the Anchor Strategic Plan and progress with Anchor activity during 2024/25. This includes Employability Programmes, Apprenticeships, Outreach Activity, and procurement activity with local businesses and small and medium enterprises.

Public Participation and Community Engagement Strategy 2025-2028

A draft Participation & Engagement Strategic Framework (staff and public versions) was approved by the Board in March 2025 noting key plans and priorities. Members enquired how delivery against the framework would be assessed and were advised that this would be built into evaluation at the beginning of every engagement process.

Also, in March 2025 NHS Forth Valley Board approved key plans and priorities for communications in 2025/26. The key areas include NHS Reform, the Population Health and Care Strategy, the CC&CL Programme, Value-Based Health and Care, Climate Change and Sustainability, Equality and Inclusion, the National Treatment Centre, the Patient Hub, and Prison Healthcare. The importance of being intentional around Equality, Diversity and Inclusion work, and preparation of EQIAs where any significant service change was being undertaken was acknowledged.

Operational Planning

In our 2024/25 ICE we reported that progress with the Delivery Plan would be reported to the SPPRC. However, no Delivery Plan update was made throughout 2024/25. Our recommendation that the SPPRC Work Planner should capture progress reporting frequency was accepted and Delivery Plan reporting in 2025/26 has been included on the SPPRC's work planner, in April 2025 and February 2026.

In April 2025 the SPPRC noted that the draft final Delivery Plan 2025/26 had been submitted to the Scottish Government on 17 March 2025, alongside the Board's Financial Plan. The Delivery Plan aligns to the Scottish Government's planning priorities 2025/26 and has a package of associated plans, also submitted in March 2025, comprising the Planned Care Plan, Workforce Plan, Anchor Plan update, and Anchor Plan

metric report. It is anticipated that the Scottish Government will approve the Delivery Plan, prior to progressing to the Board for approval, currently planned for the July 2025 Board meeting. At the April 2025 SPPRC meeting the SPPRC raised concerns over the format of the report, specifically querying its use in reviewing performance. It was agreed that, in order to provide clarity to the Board, reporting processes to the Scottish Government would be included in the paper when presenting the final draft Delivery Plan to the Board for approval.

Integration

NHS Forth Valley Board approved the revised Integration Schemes for both Falkirk and Clackmannanshire & Stirling IJBs on 28 January 2025. The Falkirk Integration Scheme has been approved by all relevant parties and has been submitted to Scottish Government for Ministerial approval, however the Clackmannanshire and Stirling Integration Scheme has still to be approved by Clackmannanshire Council. Clackmannanshire Council has initiated the dispute resolution process in a bid to resolve outstanding issues with the scheme. The most extensive revisions to the existing schemes (dated 2018) were in the finance section, in a bid to strengthen and improve the level of detail provided on financial governance and financial management, including risk sharing arrangements.

The Chief Executive of NHS Forth Valley meets regularly with the Chief Executives from Falkirk Council, Stirling Council and Clackmannanshire Council to discuss whole-system working and integration. This forms an integral part of development work.

In our ICE 2024/25 we commented on the reporting arrangements for HSCP, noting this was being worked through in the Board Assurance Framework (BAF) work. The BAF assurance framework diagram represents at a high level the reporting lines between Forth Valley and the IJBs. The BAF notes also the role of the SPPRC for planning and performance of areas related to integration arrangements. As noted in the 2024/25 ICE consideration should be given improving the timeliness and currency of information considered by the Health Board from the IJBs, with the use of brief cover papers to highlight key areas.

Performance

In common with all NHSScotland, performance against national targets is variable and challenging in certain areas. The SPPRC discussed key issues in relation to performance at their meeting on 25 April 2025, focusing on progress with the whole-system work being undertaken to meet the obligation to improve patient experience, performance around the 4-hour emergency access standard (EAS), and the number of people experiencing delayed discharge.

An improved performance against the 4-hour EAS is reported in the year to March 2025 with an overall compliance of 61.2% (to March 2024 – 56.8%). The target is 95% compliance and, nationally, the compliance rate is 63.5%. Continued focus is required to sustain and improve the position.

The 18 weeks Referral to Treatment Time target of 90% for Child & Adolescent Mental Health Services is being surpassed, with 98.4% in March 2025 compared to 95.5% in March 2024.

The number of new outpatients waiting over 12 weeks following referral is reducing, 3,322 in March 2025 compared to 5,725 in March 2024. However, the number of inpatients /day cases waiting beyond 12 weeks saw an increase, 4,177 in March 2025 compared to 2,899 in March 2024.

Collaborative work is being undertaken within the national Discharge Without Delay Working Group. 5-bedded bays are continuing to be operated, however there has been a continual reduction in open non-standard care beds and there are now no contingency beds in Ward 8 or Unit 3. Forty unfunded beds are still in use however a Test of Change is being trialled to move 30 patients off-site and work is progressing to continue to shift the balance of care nearer home. The March 2025 census position in relation to standard delays is 74 delays (March 2024 – 90). The total number of delayed discharges is 119.

Of concern is the 62-day cancer waiting time with compliance in March 2025 being 71%, against the target of 95%. This is a deterioration in quarterly performance based on March 2024 (78%) and also with the Quarter 3 (October to December) 2024 position of 79.2% and the Quarter 2 (July to September) 2024 position of 84%. The 31-day target achieved 99% compliance in the quarter to March 2025 (2024 – 97.7%).

In March 2025 draft data indicates that 79.9% of patients started psychological therapies treatment within 18 weeks of referral, against the national target of 90%. However, the total number waiting for an initial assessment in this area has increased, with 1,087 persons waiting compared to 635 at the same point in 2024.

Policies

As of 4 June 2025, 55 of 189 corporate polices (29%) were overdue for review. SLT are monitoring progress around policy update compliance. Phase 2.2 of the national "Once for Scotland" policies were due to be launched in Spring 2025 but this has been paused. Development of Phase 3 has now commenced and are due to be launched in Autumn 2025.

Environmental Management & Climate Change

The 2024/25 Performance Report within the Annual Report and Accounts includes detailed narrative on Sustainability and Environmental Reporting and disclosures related to NHS Scotland climate emergency aim. From 2025/26, a new Forth Valley Leadership Forum will bring public sector leaders together bi-annually to look at areas of collaboration in the Forth Valley area. Climate change and sustainability has been suggested as a possible area of collaboration. Further commentary on this area is included within the Financial Governance section of this report.

Resilience

Assurances on resilience arrangements are reported to the SPPRC, formerly the P&RC. A 2024/25 Annual Report of the Emergency Planning and Resilience Group (EPRG) is scheduled for presentation to the SPPRC in August 2025. The April 2025 SPPRC received the minutes of the 28 November 2024 EPRG. It was reported that the risk of lack of current and tested department business continuity plans remains high, and the P&RC (now SPPRC) is seeking reduction of this risk. We would expect that the annual report of the EPRG should be available to form part

of the suite of assurances for the June 2025 Audit & Risk Committee's consideration of the Governance Statement as part of the Annual Report and Accounts. Given the level of risk in this area, minutes should be available to the SPPRC within a timelier basis.

As of 4 June 2025, 104 Business Continuity Plans out of 245 (42%) have completed the full cycle and are signed off as complete with 49 (20%) in progress. This is an improvement on the progress last reported at November 2024.

On 24 January 2025 at 14:45 there was a full loss of power to the Forth Valley Royal Hospital site, resulting in a Major Infrastructure Failure being declared. At the time the telephone exchange was offline due to bad weather, coincidentally resulting in a complete loss of communication, lighting, and running water in areas where electrical power was needed to function. The site implemented a process of contingency plans to enable it to function and to care for patients and staff. A command structure had already been put in place due to the red weather warning. The power loss lasted around 70 minutes and there was no patient harm recorded as a result of the infrastructure failure. A full site debrief was held on 31 January 2025 with key themes and issues discussed in order to identify what worked well and what could be improved. The Board considered an assurance report on this matter in March 2025, re-iterating their thanks to all staff across the whole system who ensured that no harm came to patients during this event. Learning from this incident will feed into national resilience structures.

No.	Audit Finding	Assessment of Risk	Agreed Management Action	Responsible Officer Action by date
1	**Corporate Objectives and Outcomes** There has been no overarching summarised reporting, e.g. one-page RAG assessment, on progress against 2024/25 corporate objectives.	 **Moderate**	Through the Programme of Work, we will provide bi-annual updates to SPPRC on progress of the six Programme Boards, which will form the golden thread to the Corporate Objectives.	**Chief Executive** **31 March 2026**
2	**Transformation** The direction of travel for the transformation agenda for the board is captured within the Transformation objective deliverables, however, given the transformation and reform reflection in the 2024/25 Annual Report and Accounts, reporting on the success or otherwise against the Transformation Objective should be overt and clearly reported to the SPPRC.	 **Moderate**	As above, through the Programme of Work, we will provide bi-annual updates to SPPRC on progress of the six Programme Boards, which will link back to the Transformation Corporate Objective.	**Chief Executive** **31 March 2026**
3	**Best Value** The Committee year end Annual Report template does not include an explicit Best Value assurance section confirming that, within their relevant remits, the Committees can provide assurance that Best Value has been demonstrated in the year under review.	 **Moderate**	An explicit Best Value section will be added to the Annual Report Template for 2025/26.	**Acting Director of Strategic Planning & Performance** **31 March 2026**
4	**Board Development Sessions** The Board papers do not include a brief formal update on topics considered at Development Sessions which would provide further useful insight.	 **Merits attention**	Updates on board development sessions to be built into future Board Executive Team reports to Board.	**Board Secretary** **31 July 2025**

5	**Resilience Assurance Reporting / Timing** The Emergency Planning and Resilience Group's Annual Report is scheduled for consideration at the August 2025 SPPRC meaning that it is not available to form part of the suite of assurances for the June 2025 Audit & Risk Committee's consideration of the Governance Statement as part of the Annual Report and Accounts. Minutes of the Emergency Planning and Resilience Group are not available timeously to the SPPRC.	 **Significant**	Minutes of the Emergency Planning & Resilience Group will continue to be provided to the SPPRC as set out on the Committee Planner. The processes will be reviewed to ensure that these minutes are being made available as soon after approval as possible.	**Acting Director of Strategic Planning & Performance** **31 March 2026**

Clinical Governance

Strategic Risks:

SRR002 – Urgent and Unscheduled Care. Current score 25, target score 10.

If we do not have enough whole system capacity and flow to address key areas of improvement, there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience.

SRR004 – Scheduled Care. Current score 15, target score 5.

If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.

SRR018 - Primary Care Sustainability, Current score 15, target score 10.

If we do not have adequate resources to support and implement a Primary Care framework, there is a risk that we don't have effective measures to ensure delivery of primary care across Forth Valley, resulting in a failure to meet our statutory responsibilities, reputational impact.

Clinical Governance Strategic Framework

The most recent update on the Clinical Governance Strategic Implementation Plan was provided to the July 2024 CGC and the next update is scheduled for the July 2025 CGC.

The most recent update on implementation of the Forth Valley Quality Strategy (2021-2026) was in July 2024 and the next update is scheduled for the August 2025 CGC.

At their March 2025 meeting, the CGC reviewed and updated their Terms of Reference and Planner for 2025/26. The scope of CGC responsibility is extensive and the workplan features reporting of Standing agenda items, bi-annual reports and annual reports. The Strategic Implementation Plan and the Quality Strategy are reported annually, which may not be sufficiently frequent to inform decision making, including facilitating preventative or corrective action.

NHS Forth Valley Board receives as a standing item at all meetings, the Quality Assurance and Improvement Report, which does include an update on implementation of the NHS Forth Valley Board Quality Strategy (QS).

Clinical Governance Committee Governance and Assurance

Overall, the CGC Annual Report reflected the business considered, however, it did not contain a specific section to conclude on '*matters of concern*

to committee' as it was not produced in the standard annual report template but was instead based on the Vincent Framework. The CGC Annual Report stated that 'Assurance and Governance was provided by having an oversight and adequate reporting mechanisms from the various groups within the Clinical Governance infrastructure'. The CGC Annual Report did not conclude on adequacy and effectiveness of clinical governance arrangements.

The Whole System Assurance report to the CGC provided Reasonable Assurance at each meeting. Assurances from Clackmannanshire and Stirling Health & Social Care Partnership (HSCP) were provided in the March 2025 and May 2025 reports. However, the report stated that the Clackmannanshire and Stirling HSCP Clinical and Care Governance Group did not meet in 2024/25. Management has advised that while this group has met it has not been quorate and has been unable to provide assurances for the full year. NHS Forth Valley should assure themselves that there is no assurance gap as a consequence.

Emerging Clinical Issues is a CGC standing agenda item providing assurance on action taken to address issues of clinical concerns. The January and May 2025 CGC reports provided updates on issues and actions taken and planned in response. The January 2025 CGC minute notes the members were assured with action taken. The May 2025 minutes note that the Committee accepted the updates provided, took assurance from the actions taken and requested one further action.

The CGC received a Clinical Governance Working Group (CGWG) update report to each meeting from January 2025 onwards. This report provides a summary of key items reported to and discussed by the CGWG. The CGC considered placing this item near the start of the CGC Agenda instead of at the end, to support the flow of items to the CGC and this should be progressed.

The Professional Assurance Framework was presented to the CGC in January 2025 for noting. The next update is scheduled for August 2025. The Framework outlines the system to provide assurance on clinical staff qualifications, registration and ongoing fitness for practice. The CGC noted work was being undertaken to further develop the document and approved engagement with Staffside and the Senior Leadership Team (SLT).

The Person Centred Care report to CGC in May 2025 noted that complaints performance had deteriorated since February 2025 with demand outstripping capacity and staff resource identified as contributing to this challenge. Recruitment is underway. Combined performance across the organisation was noted as remaining between 60 to 70% between the period April 2024 to February 2025, which was a 10% improvement in comparison with 2023/24 data. The CGWG April 2025 meeting received an update on organisational risks, which included Complaints Case Backlog which was scored 20 with a target of 15. The most recent review of the risk in May 2025 to the SLT on 2 June 2025 proposed an increase in the score to 25 due to an increase in back log from 200 to 400 cases.

Regular Scottish Patient Safety Programme updates were reported to the CGC in 2024/25. The Safer Together Collaborative aims to improve patient safety through implementing evidence-based practice and focuses on identifying and addressing key areas of patient safety concern. Assurance reports are presented to the CGC. The Safer Together Collaborative aligns to all four corporate objectives, all five priorities of the Quality strategy, aims to achieve 6 commitments of Value Based Health and Care (VBHC) and align to the six domains of Healthcare Quality. Reporting on Safer Together features in the 2025/26 CGC panner, and a comprehensive report was presented to the May 2025 CGC.

A Prisons update was presented to the May 2025 CGC for assurance and highlighted several key issues for noting. These will need to be carefully monitored.

Medical Appraisal and Revalidation

The October 2024 CGWG considered the Medical Appraisal and Revalidation Quality Assurance Annual Report and 2023/24 self-assessment submission. As reported in our 2024/25 ICE, 51% of 2023/24 Medical Appraisals and Revaluation were completed as of September 2024. The process runs on a yearly cycle from April to March.

The Medical Appraisal and Revalidation Quality Assurance (MARQA) submission in May 2024 recognised the low completion rate for appraisal, particularly in secondary care, and an updated submission was requested. The completion of appraisal rate was 70% against the pre Covid rate of 90%.

The Medical Appraisal and Revalidation Annual report to the CGWG concluded '*Priorities for next year include addressing the challenges mentioned, with a view to returning towards the 90% completion rate, as well as supporting and developing the appraiser group with return of regular appraiser meetings and the introduction of individual appraiser meetings with the appraisal leads*.'

Appraisal and revalidation data was not reported to the CGC. Given the challenges identified in this area, frequency of reporting to the standing committee should be reviewed, to demonstrate progress or escalate concerns if issues are not being resolved. Management has informed us that the governance reporting route is under consideration. Whilst it is important that items of business are aligned to the most relevant standing committee, scrutiny and oversight mechanisms should remain intact until decisions are reached, and reporting arrangements are clarified.

We also note from the minute of the March 2025 CGC that Specific reference to educational governance was sought, where it was advised that such governance was undertaken by the Clinical Governance and Staff Governance Committee. It was agreed that further discussion would be undertaken by the Medical Director and Chief Executive.

Risk Management

Strategic Risk SRR002 – Urgent and Unscheduled Care has been scored at 25 throughout the year and Strategic Risk SRR004 - Scheduled Care has been scored at 15 throughout the year.

Both SRR002 - Urgent and Unscheduled Care and SRR004 - Scheduled Care were realigned from the CGC to the SPPRC when it was established. Focused risk reviews are planned for June 2025 for SRR002 - Urgent and Unscheduled Care, which is two months later than the previous CGC schedule and for August 2025 for SRR004 - Scheduled Care.

SRR016 - Out of Hours has been removed from the Strategic Risk Register, a decision supported by a formal letter from Sir Lewis Ritchie agreeing to deescalate the NHS Forth Valley Out of Hours service.

No strategic risks are currently aligned to the CGC and at the January 2025 meeting members raised concern over the lack of opportunity to capture quality and safety of care risks, and it was agreed that a further discussion regarding future risk arrangement would be undertaken.

The April 2025 SPPRC minute noted that members were advised of the ongoing work to review the alignment of strategic risks to Committees. It was noted that SRR002 - Urgent and Unscheduled Care would be realigned to the CGC due to the risk relating to patient harm, noting also the performance aspect of urgent and unscheduled care would continue to be monitored by the SPPRC through the Performance Report. The minute notes Members were supportive of the approach, and it was agreed that the proposed risk realignment would be brought back for further discussion following review.

Our previous ICE and Annual Reports have reported Internal Audit's view that Scheduled Care and Urgent and Unscheduled Care risks should predominantly focus on clinical governance aspects, specifically the potentially more significant risk of harm arising from a failure to prioritise services, and patients within those services effectively, rather than performance. It is our opinion that the CGC should be fully assured on the operation of key controls for these two risks, from a clinical governance perspective. The alignment of SRR002 - Urgent and Unscheduled Care to the SPPRC lengthened the interval between planned focussed reviews. Transition of SRR002 back to the CGC should be carefully managed to minimise any detrimental impact on the transition timeline and the interval between the last focussed review.

External Review

The report on the Care Inspectorate and Healthcare Improvement Scotland Clackmannanshire and Stirling HSCP Joint Inspection of Adult Services, published in November 2024, was reported to Board in January 2025. The report included an improvement plan and provided Limited Assurance. The Board noted that governance oversight of the improvement plan would be through the IJB.

On 17 January 2025, the determination following a Fatal Accident Inquiry related to HM Prison and Young Offenders Institution Polmont was issued and twenty-five recommendations were made. The 2024/25 Governance Statement notes that *'Changes have been made over the intervening six years to improve and strengthen prison health services and support in all three national prisons in the Forth Valley area however work was progressing to identify any actions required to further improve prison healthcare services and support the mental health and wellbeing of young people'.* We would expect that NHS Forth Valley continues to overtly monitor progress in this area.

Significant Adverse Event Review (SAER)

The 2024/25 CGC Annual Report stated that throughout the year all SAERs reports on compliance with the HIS adverse event management framework provided a limited level of assurance, noting also the routine reports also included a detailed improvement plan with measurable aims, objectives and completion dates. Performance in this area continues to be out-with the national framework targets.

The CGWG approved the revised Adverse Event Policy and Adverse Event Procedure at their April 2025 meeting. This noted increased alignment to the February 2025 HIS national framework and the associated measurement and improvement plan for adverse and significant adverse event management.

The policy and procedure review were undertaken to ensure greater alignment and support for the SAER improvement plan aims and objectives for 2025-2026 to improve compliance. The paper noted that significant associated education, training, awareness, and engagement sessions were to be delivered to support implementation. In addition to provision of a Board wide overview of performance, Directorate level compliance will be reported.

Performance against national measures is presented to CGC in graphical form. Measures relating to developing an improvement plan within 10 working days from report being approved, and for completion to be within 140 working days, are not currently reported due to the data historically not being collected. Development of these measures is part of the improvement plan. As previously reported by Internal Audit, SAER reporting to the CGC does not specifically provide performance against national targets as a percentage over a specified time period and this should be developed as part of the ongoing improvement programme.

Internal Audit A15/25 Adverse Event Management is in progress and fieldwork includes a review of a sample of completed adverse event reviews, including significant, to determine whether: an improvement action plan was developed in response to the recommendations from the review; the actions have been implemented and learning shared across the organisation; and where relevant, there is evidence to demonstrate service quality improvements. We plan to report the outcome of the audit later in the year.

Population Health

Public Health updates were presented to each of the 2024/25 CGC meetings providing Reasonable Assurance on each occasion. The March and May 2025 reports indicate the Public Health clinical governance arrangements continue to be strengthened and further embedded. The Public Health Directorate Clinical Governance Group meets bi-monthly and departmental workstreams inform the majority of the business discussed. The reports note that any areas of concern from workstreams are discussed by way of a deep dive and can be further escalated to the CGWG or the CGC as required.

The SRR020 - Health Inequalities risk is now aligned to the SPPRC. The current score is 20 (Very High), with a target score: 10 (Low) and the Population Health and Care Strategy is noted as a further required control to mitigate the Health Inequalities risk. The draft Population Health and Care Strategy 2025-2035, along with its Strategy Communications and Engagement Plan were approved in April 2025 by the Board, and approval of the final Strategy is scheduled for the September 2025 Board. A focused risk review for SRR020 is planned for the December 2025 SPPRC.

Organisational Duty of Candour

The Duty of Candour Annual Report 2024/25 is scheduled to be presented to the CGC July 2025 meeting in line with the timetable for previous Duty of Candour Annual Reports.

Clinical Policies and Procedures

From review of the Pentana system as at the end of May 2025, of 732 clinical policies and guidelines, 402 were overdue for review.

The CGWG April 2025 meeting received an update on Clinical Policies noting Limited Assurance as there were gaps in the system of internal control which left an increased risk position. The same meeting received an update on ORG Risk 21 - Clinical Policies as part of the Clinical Governance organisational risks update. The risk is assessed as high (current score of a 15, with a target score of 10/medium) with a lead impact category of Patient Harm. The risk appetite score range is 8-10 (yellow/cautious). The April 2025 report noted following a review of the current controls and mapping them to the causes assessment, gaps were identified in the current process to support effective implementation and management of

clinical policies and guidelines. A number of actions have been identified and are being progressed to mitigate this risk. This is a well-known, long standing issue and remedial action should be expedited.

The Whole System Assurance report to CGC and CGWG includes updates on policy and guidelines review within directorates as part of the 'Will care be safe in the future?' section.

Primary Care Services

The Whole System Assurance Report to each meeting of the CGWG and CGC includes assurance on clinical governance processes within primary care using the Vincent framework format.

Strategic risk SRR018 - Primary Care Sustainability is aligned to the SPPRC with the most recent focused risk review to the April 2025 meeting noting the reduction in the risk score from 20 to 15. The risk score reduction had originally been proposed as part of the focused review presented to the June 2024 SGC and then to the September 2024 SGC, with the SGC questioning the reduction of the risk score and asking for a re-evaluation of the score reduction, considering the report's limited assurance. Management has advised that whilst this work was ongoing, the risk continued to be monitored and reviewed at the risk score of 15.

The April 2025 SPPRC discussed the focused review at length, noting concerns around the risk description and gaps in controls. Further work was requested and there were no further comments on the risk score. Limited Assurance was however provided to the April SPPRC as the risk was outwith appetite and tolerance. The report noted that although there were actions identified to reduce the risk over time, the risk was significantly impacted by external factors such as national funding and recruitment challenges and the impact of the cost-of-living crisis which are difficult to mitigate against internally. There were seven identified mitigating controls, one RAG assessed as green, two yellow, one amber and three red. Two further actions were identified in relation to development of governance routes and escalation procedures following the delegation of primary care to Falkirk HSCP, and development of a whole-system Community Health & Wellbeing Transformation Programme.

The April 2025 SPPRC agreed to actions to: Reframe risk description to focus on patient impact; include reference to the Population Healthcare Strategy, national strategies, and planning authorisation; consider reframing Control 2: Recruitment & Retention to reflect the complexity of expectations of General Practices; schedule a further Primary Care Sustainability Strategic Risk Update within the year.

Given the nature of the further controls required to manage strategic risk SRR0018, and the concerns noted by the SPPRC members in April, the revised risk score may not reflect the nature of the challenges to successfully mitigate concerns in this area. We welcome the SPPRC request to schedule a further Primary Care Sustainability Strategic Risk Update within the year.

No.	Audit Finding	Assessment of Risk	Management Response / Action	Responsible Officer Action by date
6	**Strategy Reporting** The CGC workplan features reporting of Standing agenda items, bi-annual reports and annual reports. The Strategic Implementation Plan and the Quality Strategy are reported to CGC annually, which may not be sufficiently frequent to inform decision making, including facilitating preventative or corrective action.	 **Moderate**	The CGC has recently reviewed its forward planner and there were no requests for more frequent updates as the Strategy is a long-term programme. This will be kept under review and the Board are to review the Quality Strategy progress in July 2025.	**Medical Director** **31 July 2025**
7	**CGC Annual Report Conclusion** The CGC Annual Report 2024/25 is a key source of assurance to inform the Governance Statement. The report stated that *'Assurance and Governance was provided by having an oversight and adequate reporting mechanisms from the various groups within the Clinical Governance infrastructure'.* The CGC Annual Report did not however conclude on adequacy and effectiveness of clinical governance arrangements, in line with the revised Board annual report template and Committee Assurance Principles.	 **Moderate**	The most recent Annual Report was based on the previous one and compiled by the new Head of CG who would not have been aware of the revised template and principles, hence the lack of a statement regarding adequacy and effectiveness. This is an oversight which can be amended at next CGC.	**Head of Clinical Governance** **31 August 2025**
8	**Strategic Risk Alignment** Work is ongoing to review the alignment of strategic risks to Committees and risk SRR002 - Urgent and Unscheduled Care will be realigned to the CGC due to the risk relating to patient	 **Significiant**	Getting the balance between reporting unscheduled and scheduled care harm and safety risks and demarcating and referring performance risks to an appropriate forum will need to be discussed with	**Corporate Risk Manager** **Director of Acute Services** **Medical Director** **31 August 2025**

	harm, noting also the performance aspect of urgent and unscheduled care would continue to be monitored by the SPPRC through the Performance Report. Internal Audit's view is that Scheduled Care and Urgent and Unscheduled Care risks should predominantly focus on clinical governance aspects, specifically the potentially more significant risk of harm arising from a failure to prioritise services, and patients within those services effectively, rather than performance. In our view, the CGC should be fully assured on the operation of key controls for both the Scheduled Care and the Urgent and Unscheduled Care risks, from a clinical governance perspective. The interval between planned focused reviews requires careful management to minimise any detrimental impact as a result of risk realignment to CGC.		the Corporate Risk Manager and unscheduled leads to shape the reporting, and the Chair of CGC to ensure the balance is maintained.	
9	**Whole System Assurances** The Whole System Assurance report to the CGC did not provide robust assurance from Clackmannanshire and Stirling HSCP for the full year. There is currently no representation at the CGC from Falkirk and Clackmannanshire & Stirling HSCPs. As a consequence, there may be an assurance gap that the CGC would wish to address.	 **Moderate**	The Whole System report continues to develop and there is an expectation that C&S CCG reporting will provide much more assurance in 2025/26. It will be kept under review. Falkirk HSCP has recently restructured its governance structures and these will strengthen read across to CGC.	**Head of Clinical Governance** **31 March 2026**

10	**Medical Appraisal & Revalidation Reporting** The Medical Appraisal and Revalidation Quality Assurance Annual Report was not reported to the CGC during 2024/25, as planned. A number of challenges in this area have been identified and reported to the CGWG and Management has informed us that the governance reporting route is under consideration. Whilst it is important that items of business are aligned to the most relevant standing committee, scrutiny and oversight mechanisms should remain intact until decisions are reached, and reporting arrangements are clarified. The route for educational governance reporting is also under review.	 **Significiant**	Agreed and the omission of the MARQA reporting to CGC will be remedied for 2025/26.	**Medical Director** **31 December 2025**

Staff Governance

Strategic Risks:

SRR009 Workforce Plans – Very High Risk (20); Target (10) Medium

If NHS Forth Valley does not implement effective, fully costed strategic workforce planning based on projected demand there is a risk that we will not have a sustainable workforce that is the right size, with the right skills and competencies, within an affordable budget, resulting in significant pressures on staff health and wellbeing, sub-optimal service delivery to the public, and increasing pressure on our financial sustainability.

SRR019 Culture and Leadership - High Risk (15); Target (10) Medium

If NHS Forth Valley does not foster a cohesive culture with strong leadership, there is a risk that our people will not feel valued in their roles and understand how they feed into organisational success, resulting in a negative impact on staff morale, and an inability for NHS Forth Valley to be resilient, agile, and achieve long-term success.

Workforce Planning

Recognising the workload pressures facing NHS Boards and HSCPs, as well as the difficulty in planning for workforce in the current environment, the Scottish Government issued DL (2024) 33 in December 2024. This confirmed that Boards need not submit a 3-year workforce plan but, instead, must submit specific workforce information by 17 March 2025. DL (2024) 33 stated *'it remains the advice from Scottish Government that NHS Boards & HSCPs continue to plan for their workforces using a methodology, timeframe and structure that best suits their organisational needs.'*

The March 2025 Staff Governance Committee (SGC) endorsed the submission to be sent to the Scottish Government by the deadline date and noted that a review of the Workforce Planning Guidance would be carried out by Scottish Government over the coming year (2025/26), to ensure that it meets their aims of aligning planning process and any reform agenda along with the intention to review workforce planning procedures in NHS Forth Valley.

The same meeting considered a National Workforce Strategy paper which provided an update on National Workforce Planning expectations for NHS Forth Valley.

As the SGC moves to a 6-meeting annual cycle in 2025/26, workforce planning updates are scheduled for every second meeting to give appropriate priority to this critical area. Recognising there will be uncertainty whilst the Scottish Government undertakes a review of national workforce planning guidance, the Board should continue to plan and ensure that appropriate updates are provided to the SGC and that they are sufficiently assured that NHS Forth Valley is doing all that they can to progress workforce planning.

Workforce Risks

During 2024/25, the SGC continued to review the Strategic Risks assigned to it, which remain high or very high.

An update on the Workforce Plans risk SRR009 presented to the May 2025 SGC confirmed that a routine risk review had been undertaken in May 2025 and that progress had been made on the further controls with each action being updated. The completion dates were extended to await feedback from the Scottish Government on the workforce data submitted in March 2025, but feedback has yet to be provided. Since feedback has not been forthcoming, the SGC should consider setting target completion dates for the controls.

A10/25 ICE 2024/25 recommended that the gaps identified in the existing 'absolutely critical' Overarching Workforce Plan and Directorate / Service Workforce Plans controls should be implemented as a matter of urgency. The original target completion date for this action was 31 May 2025 but the paper to the May 2025 SGC proposed extending this to 31 July 2025, to align with a more comprehensive review of programme governance within NHS Forth Valley. A focused review of the risk was not undertaken at the May 2025 SGC, as previously recommended by Internal Audit and the first focused review of the risk is scheduled for the July 2025 SGC. Our recommendation was assessed as 'significant' requiring action to avoid exposure to significant risks to achieving objectives, therefore completion of the actions should be prioritised for early completion.

Risk SRR019 Culture and Leadership was routinely reviewed in May 2025 with no change to its score. The Culture Change & Compassionate Leadership Programme Phase 1 of project mobilisation is complete, and Phase 2 commenced on 8 May 2025, with the aim to have all workstreams mobilised by the end of June 2025. Launch events for the Phase 2 workstreams have started.

The Director of People has advised that areas of focus for improvement, noting connections to the Strategic Workforce Risks, are acknowledged. As well as focussed reviews built into the 2025/26 Workplan, there are plans to report on workforce planning and cultural improvement work through the Culture Change & Compassionate Leadership Programme, including action plans connected to work in both respects.

Risk SRR018 Primary Care Sustainability was reassigned from the SGC to the SPPRC during the year. Management has informed us that a review of the risk assigned to Standing Committees is ongoing.

Staff Governance Committee

The draft Annual Report of the Committee for 2025/26, approved at the May 2025 SGC, concluded that "….*the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Staff Governance Committee, adequate and effective arrangements were in place throughout the year*."

We have observed improvement in the operation of the SGC compared to 2023/24. The appointment to the substantive post of Director of People has provided leadership and focus, we would however emphasise the importance of maintaining progress in this area. Given the challenges highlighted to the SGC during 2024/25 around workforce planning and acknowledging the good work that has been undertaken such as the reporting of Safe Staffing, eRostering /Safe Care roll out and nursing blueprint, we would have expected to see some reference to this in the 'Matters of concern to the Committee' section of the SGC Annual Report.

Where the SGC have identified areas of concern around compliance or performance, Committee Assurance principles note that '*Detailed scrutiny should take place at Standing Committee level, with each Committee providing assurance and escalating key issues to the Board as required. For this to be achieved successfully, Standing Committees must be clear about their priorities, have focused agendas and workplans and must monitor*

their own performance rigorously'. For areas where the SGC have identified areas of concern in their Annual Report (e.g. training compliance) it would be appropriate to articulate how the SGC plan to manage the risk going forward and how assurance will be provided to the Committee.

The latest Internal Audit Follow-Up report to the May 2025 SGC showed four outstanding actions, with two proposed for closure. This did not include actions from A21/25 Management of Sickness Absence (6 actions – 1 significant, 5 moderate), which was being presented to the SGC as a separate agenda item, following which actions would be incorporated into future updates.

Workforce Strategy (People Strategy)

Our ICE 2024/25 reported that, linked to the ongoing development of the Population Health and Care Strategy, engagement on People Strategy elements would be progressed, noting that a decision is pending on whether the People Strategy will be incorporated into the wider strategy or be a standalone strategy.

The draft Population Health and Care Strategy was shared publicly on 1 May 2025, inviting the public to have their say on the way health and care will be delivered across the region over the next decade. Section 6 of the draft Strategy references 'Our Workforce' stating "*We will develop our approach to workforce planning through our enabling People Strategy to support effective delivery of our strategic priorities*." The current plan is the People Strategy is likely to be included for approval by the SGC in March 2026. The SGC Workplan 2025/26 does not have a fixed date for completion of the Strategy, though it is included with a 'to be confirmed' date. Progress to develop an overarching People Strategy, linked to the now-issued draft Population Health and Care Strategy, from which workforce plans will flow and support is critical, and we suggest that firm milestone dates be included in the SGC's workplan for 2025/26 to facilitate focus and to ensure that the SGC monitor developments and receive assurance with progress on this key supporting strategy.

Staff Governance Assurances

The SGC continued to receive quarterly Staff Governance reports, setting out workforce metrics.

Our ICE 2024/25 reported that the NHS Forth Valley Staff Governance Action Plan was due to be reviewed by the SGC in March 2025, as per the December 2024 SGC Workplan. Staff Governance Standard Action Plans by Directorate and a December 2024 letter to Scottish Workforce and SGC Co-Chairs were also on the workplan for presentation in March 2025. The Staff Governance Action Plan update was not presented as planned and was removed from the workplan due to the approach being reviewed in line with the developing performance reporting which will commence in the 2025/26 cycle. The 2025/26 SGC Workplan at May 2025 does not indicate a confirmed timeline for an update to the Committee on the Staff Governance Action Plan.

The SGC considered the iMatter National Report 2024 and Outline Plan for the 2025 cycle at their May 2025 meeting. NHS Forth Valley's response rate of 58% (2023 61%) was the same as the national response rate. NHS Forth Valley agreed 61% of action plans within the 8-week window, against a national result of 56%. Areas where NHS Forth Valley could continue to improve included: continuation of CEO briefings and drop-in Teams sessions, continuation of Board Walkabouts, and continuation of the 'Step in my Shoes' programme. The May 2025 iMatter report included the planned iMatter timeline for 2025 between April and August 2025.

Staff Governance Monitoring exercise

The Staff Governance Monitoring Exercise has been paused by the Scottish Government, but NHS Boards are still expected to maintain local monitoring of the Staff Governance Standard. The local focus in NHS Forth Valley is to develop performance reporting to monitor action plans. Monitoring information is being populated onto the Pentana system by services to support future Scottish Government requests for monitoring data. The Director of People has informed us that learning from the Pentana reporting development work is to be used to further develop workforce planning monitoring of action plans. Aligned to this work is ongoing around governance reporting to the new Strategic Workforce Programme Board and to SGC as appropriate.

Training, Development and Appraisal

As of April 2025 for Agenda for Change Staff the reported completion rate of signed off Personal Development and Planning Reviews was 36.9%. The national target is 80% and this is clearly an area for improvement. We have been informed that Executive Directors have been asked to identify realistic trajectories to progress raising compliance levels to 80% and sustain this.

Full year data shows 67.7% (2023/24 51.2%) of eligible Secondary Care Appraisals for 2024/25 were completed and 100% (2023/24 96.5%) of eligible GP Appraisals were completed.

In December 2024 members of the SGC raised concern about the decrease in training compliance with Violence and Aggression modules, noting that incidents of violence and aggression had increased by 14% since the prior quarter. It was agreed that assurance needed to be sought that appropriate actions were being taken to address these issues. The SLT escalated this to an organisational risk with a team formed to produce an action plan to improve compliance. Monitoring of organisational risks is being embedded in the SLT work programme, which should provide the opportunity for this new risk to be monitored.

Whilst recognising that low completion rates can be an indicator of service pressures, NHS Forth Valley should consider what action can be taken to improve the completion rate, to support staff in their roles. Improvement actions should be monitored by the SGC.

Remuneration Committee

The Terms of Reference of the Remuneration Committee were revised and approved at the March 2025 SGC. Internal Audit offered feedback for the Committee's consideration and one adjustment was made relating to approval of Remuneration Committee membership being subject to final Board endorsement. A revised Terms of Reference was then approved at the May 2025 SGC for future endorsement by the Board, planned for July 2025.

The updated terms of reference of the Remuneration Committee state that *"the Remuneration Committee will submit their annual report through the Staff Governance Committee for review and the Staff Governance Committee will recommend approval to the Board. This will give relevant assurance to the Board and Accountable Officer relating to the Governance Statement".* In compliance with this a draft Remuneration Committee Annual Report 2024/25 was considered at the May 2025 SGC meeting.

The Remuneration Committee Annual Report concluded that "*From the review of the performance of the Remuneration Committee it can be confirmed that the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Staff Governance Committee, adequate and effective arrangements were in place throughout the year*".

In January 2025 NHS Forth Valley received formal confirmation from the National Performance Management Committee (NPMC) that they were content with the appraisal outcomes for the Board for 2023/24.

An Executive Team development session took place in April 2025 to commence the process of objective setting for 2025/26. An approach has been agreed to setting objectives which align to Corporate Objectives.

Whilst the Remuneration Committee completes an informal Self-Assessment proforma after each meeting, a full self-assessment against the NHS Scotland Remuneration Committee Self-Assessment pack has not been undertaken. As a commitment to on-going development, an annual full-self assessment should be factored into the 2025/26 Workplan.

Attendance Management

NHS Forth Valley's sickness absence rate in March 2025 was 7.03% an increase of 0.3% since March 2024.

Internal audit A21/25 Management of Sickness Absence was issued on 26 March 2025 and provided Limited Assurance. We concluded that whilst work had progressed since the initial iteration of the Attendance Management Action Plan in March 2023, and recognising challenges due to changes in key personnel, the pace of completion of the Attendance Management Action plan actions needed to be accelerated, and six audit actions were identified. The audit actions were agreed by management and completion dates between June and November 2025 have been agreed.

Staff Wellbeing

Staff Support and Wellbeing updates are included as part of the SGC's annual workplan with input also being provided to the 'Safe, Well and Heard' workstream of the Culture Change & Compassionate Leadership programme.

The Culture Change & Compassionate Leadership Programme, launched in April 2023, focuses on improving workplace culture through collaboration and addressing issues such as leadership, wellbeing, and communication. Key initiatives in 2025/26 will include fostering a psychologically safe culture, improving personal development plans, and developing compassionate leadership to reduce absenteeism. The iMatter update to the 13 May 2025 SGC noted "*while there could be some things to be content with, a different approach and focus may be required moving forward in order to see the improvements that are necessary at NHS FV, particularly with the ongoing work in the Culture and Compassionate Leadership programme*". The continuing high sickness absence rate, with the main reason for absence being anxiety, stress, depression (34.5% of the total in March 2025) emphasises the importance of the Culture Change & Compassionate Leadership Programme and the need for the programme to effect change in this area.

A Workforce Wellbeing Plan 2025-2029 is due to be launched in September 2025.

The Equality and Inclusion Strategy 2025-2029 was approved by the Board on 29 April 2025. The document commented on the Boards previous Equality Outcomes for April 2024 to April 2025 (Objective One - Improving Accessibility; Objective Two - Awareness, Communication and Engagement; Objective Three - Training and Education; and Objective Four - Supporting our Workforce), noting '*These outcomes, after review and consultation, have been updated to reflect our learning and current need. We are proud of the progress we have made over the last year but appreciate there is still a lot more to do. That's why there is continuation of these outcomes into our 2025 to 2029 proposed Equality Outcomes as we want to invest more time and resources into associated actions and workstreams that progress these areas'*. This strategy includes reports required under the Public Sector Equality Duty, namely: (1) Equality Mainstreaming Report (2) Equality Outcomes for 2024-2029 (3) Gender Pay Gap (4) Equal Pay Statement (5) Workforce Monitoring Report.

Health and Safety

Compliance with manual handling training in Quarter 4 2024/25 was 62%, from 72% in Quarter 1 and below the 90% target set in March 2022. Compliance with Violence and Aggression training for Quarter 4 2024/25 was 61%, a reduction for the Quarter 1 position of 67%, remaining significantly below the 90% target. As noted in the 'Training' section above, a team has been formed to produce an action plan to improve compliance.

Historic adverse events awaiting review and / or return of Managers forms longer than the KPI (9 days) has significantly increased from 250 in Q3 to 365 in Q4. Whilst this is lower than that reported in Q2 (495) the increase is of concern and suggests that "*the reviewing of adverse events may not be embedded into business-as-usual processes*". Quarter 3 compliance with review of adverse events within the 9-day KPI remained at 73%, compared to Quarter 2, against a target of 100%.

Key to the success of the Health and Safety Control Book audit programme is that actions identified are followed through. A self-reporting monitoring approach is adopted with 64 of the 117 books audited providing a response (55%). This remains significantly short of the 90% compliance that is required. Engagement from the Acute Services Directorate decreased from 35% reported in Q3 to 15% in Q4. The Q4 Health and Safety report indicates that 30 areas that did not engage in the Q3 control book audit assurance process were followed up by the Health & Safety Team who offered support. None provided an update on progress in Q4.

Performance in various aspects of Health and Safety conformance is below the required level. We would expect the SGC to continue to request further information to provide assurance that controls are in place and working appropriately to mitigate any associated risk.

The Annual Safe Staffing Report 2025 was approved by the SGC in March 2025, concluding a reasonable level of assurance on the organisation's compliance with the 2019 Act, before progression to the Board for approval and publication thereafter. The cover paper concluded that NHS Forth Valley had made good progress and that where gaps have been identified, there are plans in place to resolve these. Further assessment and reporting will keep groups on track to ensure NHS Forth Valley is working towards full compliance with the legislation. Monitoring arrangements are in place across the operational delivery units with the intention to ensure that appropriate mechanisms of accountability and responsibility are in place, and functioning. Management have informed us that Health Improvement Scotland (HIS) have asked questions as part of their assurance process, and NHS Forth Valley have provided feedback as appropriate. The latest engagement call with HIS was 28 May 2025 where

management have also confirmed that HIS are satisfied with the Board's compliance and there are no plans to issue any formal feedback to the Board.

Whistleblowing

Quarterly Whistleblowing updates were provided to the SGC and Forth Valley NHS Board and a Whistleblowing Annual Report was presented for assurance to the May 2025 meeting of SGC and Forth Valley NHS Board. The Annual Report stated that "*NHS FV has robust reporting arrangements to ensure all national reporting has been through internal governance arrangements in a timely manner to allow national reporting to be in line with the Whistleblowing standards. This gives the assurance that NHS Forth Valley is meeting national reporting requirements*".

The report details the comprehensive arrangements in place within NHS Forth Valley to encourage staff to feel able to raise issues.

The 2024/25 Whistleblowing Annual Report details 5,081 staff (73%) have completed overview training, up from 3,997 (59%) in 2023/24 against the national target of 90%. In the 2023/24 Whistleblowing Annual Report it was noted that NHS Forth Valley had set a 2024/25 year end trajectory for 70%.

It is recognised that there is a need to give attention to senior / line managers training, and a space for capturing this data was created on the Pentana performance system. At the end of March 2025 19% of line managers and 11% of senior managers had completed the training most appropriate for their role.

The Independent National Whistleblowing Officer's (INWO) expectation is that Stage 2 concerns are closed within 20 working days. Due to the complexity of the concerns, an average of 55 working days was taken to complete Stage 2 concerns, compared to 53 days in 2023/24. It is recognised that a thorough investigation of complex issues takes time, and work continues to eliminate avoidable delays and provide continued support for reporters throughout the process.

The INWO has considered a total of five concerns under the standards. One in 2023/24 and three in 2024/25. A further report was published in April 2025 which will be included in the 2025/26 Annual Report.

No.	Audit Finding	Assessment of Risk	Management Response / Action	Responsible Officer Action by date
11	**Staff Governance Committee Annual Report** Where the SGC have identified areas of concern around compliance or performance, Internal Audit's Committee Assurance principles note that 'Detailed scrutiny should take place at Standing Committee level, with each Committee providing assurance and escalating key issues to the Board as required. For this to be achieved successfully, Standing Committees must be clear about their priorities, have focused agendas and workplans and must monitor their own performance rigorously'. For areas where the SGC have identified areas of concern in their Annual Report it would be appropriate to articulate how the SGC intend to scrutinise, monitor, and manage the risk going forward.	 **Significant**	We accept the principle around clear assurance and escalation arrangements for areas of risk. As this relates to the highlighting of concerns in annual reporting, we will ensure this is reflected in our next SGC annual report. In relation to this specific issue, proposals are being brought back to SGC in relation to management and governance for our workforce planning risk. This will lay out adjustments to our approach and will give the committee the opportunity to consider reporting arrangements to ensure it is provided with appropriate assurance that all actions/mitigations are being progressed. This will build on the positive steps in relation to Safe Staffing, workforce establishment/blueprint development, supplementary staffing savings and governance enhancement through our new strategic programme structure.	**Director of People** **30 September 2025**
12	**Development of the People Strategy** Milestone dates for completion and review of the critical People Strategy should be specified in SGC's workplan.	 **Moderate**	This issue has been flagged to SGC as part of workplan reporting. The timescale for completion of the strategy will be finalised on approval of the Population Health & Care Strategy, noting that work in relation	**Director of People** **30 September 2025**

			to our People Strategy will continue to progress through our strategic programme delivery model.	
13	**Health & Safety Compliance Performance** Performance in various aspects of Health & Safety conformance is below the required level. The SGC should request further information to provide assurance that controls are in place and working appropriately to mitigate any associated risk.	 **Significant**	The Staff Governance Committee has requested additional assurance in terms of Health & Safety Compliance Performance. The Senior Leadership Team has prioritised actions to progress this work, and a commitment has been made to report back to the committee in July. Ongoing reporting will be provided thereafter to ensure improvements are delivered.	**Director of People/Director of Finance** **31 July 2025**

Financial Governance

Strategic Risks:

SRR005 Financial Sustainability – Current Score 25 (very high); Target Score 15

If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, a detrimental impact on current / future service provision, and an impact on our reputation.

SRR010 Estates and Supporting Infrastructure – Current Score 16 (high); Target Score 6

If a whole system, multidisciplinary approach is not applied, there is a risk that we will not make best use of available capital and revenue funding, via prioritisation and allocation, to fully proceed with existing Estates and Infrastructure plans, make new development plans, or maintain and enhance the existing estate. This will result in an inability to maintain and develop a suitable environment for modern and sustainable services.

SRR017 Environmental Sustainability and Climate Change – Current Score 20 (very high); Targe Score 15

If NHS Forth Valley does not maximise our available resources to implement our Climate Emergency & Sustainability Strategy, there is a risk that we will be unable to comply with DL38 and not meet the requirements of the Scottish Government Climate Emergency & Sustainability Strategy resulting in an inability to operate in an environmentally sustainable manner, an inability to meet objectives, and damaging stakeholder / public confidence.

Economic Environment

A key message from Audit Scotland's national 'NHS in Scotland 2024' report, published in December 2024, was: "*Costs are forecast to continue rising, identifying and making savings remains challenging, and investment in new healthcare facilities remains paused. To address current financial pressures, fundamental change in how NHS services are provided is now urgently needed*". In the context of this very challenging situation NHS Forth Valley met their financial targets for 2024/25, albeit this was achieved partly through significant unplanned additional funding and reduction in planned costs. An ambitious Financial Sustainability Action Plan (FSAP) delivered some successes in 2024/25 and the momentum to plan for and continue to make recurring savings must be maintained. This message has been clearly communicated through financial reporting.

Financial Performance and Reporting

The five-year 2024/25 to 2028/29 Financial Plan was approved by the Board on 26 March 2024. At that time, the revenue financial gap before savings in 2024/25 was £58.3 million. A savings plan of £43.8 million left a residual funding gap of £14.5 million, for which mitigations needed to be found. The Capital Plan forecast was for a breakeven position against £9.4 million funding.

The Scottish Government, through the national Sustainability & Value programme, set a 3% minimum recurring savings on baseline funding targets for all territorial NHS Boards. For Forth Valley this equated to £20.1 million, £7.8 million of which related to services delegated to IJBs.

The draft financial outturn position to 31 March 2025, subject to external audit review, is:

- A £0.239 million underspend against the Revenue Resource Limit (RRL) of £953.9 million
- A break-even position against the Capital Resources Limit (CRL) of £12.8 million
- A break-even position against the cash requirement, with a closing bank balance of <£0.05 million
- The 2024/25 savings target of £43.8 million was not delivered in full, with £34.1 million delivered in-year, £16.2 million of which was recurring, against a target of £21.7 million recurring.

The small underspend in 2024/25 was only possible following receipt of significant additional unplanned funding from Scottish Government, and changes in key planning assumptions such as a late reduction in Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) costs. The non-recurring nature of these one-off payments late in the financial year do not assist in mitigating the underlying recurring financial gap of £49.2million (6.4% of baseline revenue funding) carried forward into 2025/26. The need for sustainable cost improvement and enhanced financial controls to support a path to recurring financial balance will continue to be necessary.

Significant financial challenges were experienced throughout the year, particularly within the Acute Services Directorate where the full year overspend was over £26 million (circa £19 million in 2023/24). Whilst good progress was made over summer 2024 to close contingency beds on a phased basis, this could not be sustained during winter due to a peak in flu and respiratory admissions.

Whilst the final outturn positions for both IJBs is not confirmed, the NHS Forth Valley outturn is based on latest forecasts that a risk share payment of circa £5 million to Clackmannanshire & Stirling IJB, consistent with the risk sharing approach taken in previous years, will be required. The final apportionment method has not yet formally been agreed by the parties.

Financial reporting to the Performance & Resources Committee (P&RC) / SPPRC and Board remained consistent, and the position and challenges were clearly presented. We previously recommended that the final Month 12 outturn report should detail material unplanned changes throughout the year. Whilst some action has been taken to address this point, provision of further detail would be beneficial, particularly in clearly reporting the unplanned funding that has ultimately enabled the Board to deliver a breakeven position.

Transformation and Savings

An ambitious savings target of £43.8 million was identified for 2024/25, £21.6 million (49%) of which was recurring and £22.2 million (51%) non-recurring. The Director of Finance explained that initial indications were that up to 70% of the savings plan was considered high risk at that early stage of the year. By year-end savings of £34.1 million (78% of target) had been delivered, with £16.2 million delivered on a recurring basis against a target of £21.7 million recurring (75%).

Good progress was made in relation to nurse agency staff in line with recommendations from the national Supplementary Staffing Task and Finish Group. Additional local work to agree nurse staffing establishment levels has been implemented and escalation / authorisation procedures for approval of supplementary staff usage has been reintroduced. This resulted in an £11.8 million reduction in nurse agency

costs compared to 2023/24. As expected, an element of previous nurse agency usage switched to the nurse bank, but focused work in the last few months of the year resulted in nurse bank costs being £0.1 million lower than the previous year. The Celebrating Success – Nursing Workforce Review report to the 27 May 2025 Board notes '*In terms of financial sustainability benefits, the improvement work has delivered a £11.7 million [actual - £11.8 million agency and £0.1 million bank] cost reduction and alongside the investment in substantive staff has shown an overall cost saving of around £1.8 million*'. The focus in future is to return the nursing workforce back to budgeted establishment levels, along with reviewing the Medical and Allied Health Professional workforces taking account of the established nursing processes.

Internal audit A24/25 Savings Governance was issued in final form on 13 March 2025 and provided Reasonable Assurance that NHS Forth Valley had formulated and developed an appropriate, realistic, and comprehensive plan to achieve savings, and that there were robust governance, reporting, and monitoring arrangements in place to allow committee members to fully understand the financial position and draw conclusions on risks. A key message in the report was that some savings targets were optimistic, though it is acknowledged that the Director of Finance had assessed circa 70% of the savings as high risk at the start of the financial year, and that lessons learned from this exercise should be taken forward into future iterations of the savings plan.

The Delivery Plan 2025/26 is aligned to areas such as finance, savings, and workforce and recognises the challenging financial position and that embracing whole-system reform will be needed. It acknowledges that difficult decisions will be necessary, and these will be made with a focus on maintaining high-quality, sustainable services. Four key priorities underpin the financial plan, aligned with the Population Health and Care Strategy, these being:

1. Stewardship and Culture
2. Value Based Health and Care Programme
3. Refreshed Financial Sustainability Action Plan
4. Exit Strategies for Unfunded Areas

The Workforce Plan 2025 is included within the Delivery Plan and there are aspects of this plan with linkages to savings, such as reducing sickness absence, that are intended to result in financial benefits. An April 2025 update to the Financial Stewardship Board estimated the total additional cost of sickness absence above the 4% target level for the board is between £6.7 million and £9.4 million. Managing sickness absence to a more sustainable level could generate significant financial savings for the Board. The Workforce Plan draws together how eHealth solutions are being used to improve performance, initiatives to retain and attract staff to the workforce and NHS Forth Valley's location-specific challenges.

The April 2025 SPPRC also approved a Digital Plan 2025/26, supported by a balanced budget, with investment from capital and national strategic funding sources. This Digital Plan prioritises and categorises projects with a benefits realisation approach. If this plan is successfully deployed this could support the board in its journey to become financially sustainable.

In a Special meeting of the NHS Board on 29 April 2025 the paper and requirements from the NHS Scotland Executive Group on collaboration were endorsed. This is part of the national NHS Renewal Plan and will be underpinned by a national Operational Improvement Plan, a 10-year Population Health Framework and a Service Reform Framework. The aim is to foster a more collaborative ethos within NHS Scotland, with Boards urged to adopt a systematic approach to balancing local delivery with the broader responsibility of meeting the needs of larger populations beyond their geographical boundaries in the delivery of planned care. The board's involvement in this national activity has the potential to support sustainability, however, there may be risk associated with this and the board may need to carefully balance local plans and responsibilities with national activity with a delivery timeline that the board may not be able to influence.

Best Value

The Board aims to embed quality at all levels throughout the organisation and Directors and Managers are encouraged to review, identify and improve the efficient and effective use of resources.

The Board Assurance Framework approved by the Board in March 2025, supported by the Performance Management Framework and Risk Management Strategy, aims to help the Board and its committees to discharge their overall governance responsibilities and aligns with the ethos of Best Value.

Financial Planning 2025/26

The Financial Plan 2025/26 to 2027/28 was approved by Board on 25 March 2025. It set out a three-year strategy to restore recurring financial balance through whole system reform and innovation, guided by the principles of Value Based Health and Care. It reflected feedback from the Scottish Government on the draft submitted in February 2025. It also reflected the Scottish Government's refreshed '15 box grid', which directs Boards to the areas considered to offer the greatest opportunities in savings, productivity, and efficiency, together with associated actions by the Scottish Government.

The Value Based Health and Care programme is intended to drive forward the required redesign and reform of services and facilitate a shift in resources towards prevention and early intervention. It is recognised that the programme must be delivered at pace and will require challenging decisions to be taken on priorities and disinvestment.

A summary of the revenue projections for the next 3 years is detailed below:

	2025-26 £m			**2026-27 £m**			**2027-28 £m**		
	Rec	Non-Rec	**Total**	Rec	Non-Rec	**Total**	Rec	Non-Rec	**Total**
Financial Gap before savings	(49.155)	11.120	**(38.035)**	(47.423)	(1.746)	**(49.169)**	(36.395)	(0.605)	**(37.000)**
Savings	19.000	19.035	**38.035**	30.000	12.000	**42.000**	36.000	1.000	**37.000**
Residual deficit	(30.155)	30.155	**0.000**	(17.432)	10.254	**(7.169)**	(0.395)	0.395	**0.000**

The latest Finance Report to the Board on 27 May 2025 reported a £2.2 million revenue overspend for Month 1 of 2025/26 and states that *"this is of concern at this early stage of the year and prompt corrective action is required to address this in the first quarter….delivery of breakeven is a statutory requirement and every effort must be made to deliver financial targets in year"*.

Following successes in some workstreams within the Financial Sustainability Action Plan 2024/25, the work to move towards financial sustainability continues. The Financial Stewardship Programme (previously the Financial Sustainability Oversight Board) has drafted an action plan for 2025/26, building on and carrying over workstreams from 2024/25 and aligning these with Scottish Government's refreshed '15-point grid'.

The Scottish Government confirmed approval of the Financial Plan on 31 March 2025, acknowledging the significant work undertaken to set out a breakeven plan in 2025/26 and setting out expectations of continued regular engagement with Scottish Government colleagues. The next steps set for the Board by the Scottish Government are:

- Reviewing progress on delivery of the savings plan.
- Discuss any emerging risks and mitigating actions being taken by the Board.
- Discuss progress with the areas of focus set out in the revised 15-box grid, and any support the Scottish Government can provide.
- Engage and seek pro-active involvement in enabling national programmes as they develop in 2025/26.
- Work collaboratively to identify further measures to reduce the Board's residual recurring financial gap.

The Scottish Government have stated they recognise the importance of providing certainty over funding which allows NHS Boards to focus on delivering key outcomes. The Scottish Government's Health and Social Care Directorates are reviewing all allocations to identify which can be baselined, bundled, or issued early in 2025/26.

Financial Risk

The Financial Sustainability strategic risk SRR005 remains at the maximum score (25), as it has been since Quarter 4 2021/22, reflecting the sustained and extremely challenging financial pressures on the Board and Scotland-wide.

A focused review of the Financial Sustainability risk was considered by the SPPRC in February 2025. This provided Reasonable Assurance in relation to the financial controls in place but Limited Assurance in relation to the volatility of the external financial environment. The number of controls in place was reduced to 6 (from 11), amalgamating similar controls e.g. structured savings plans merged with the Financial Sustainability Action Plan.

Some gaps were identified in the review and actions identified to close these. Five further controls were identified, two of which were assessed as absolutely critical: (1) Completion of the Population Health and Care Strategy (now issued for public engagement) and (2) finalise decisions around unfunded services (due March 2025; work continuing within the Financial Stewardship Group).

Whole System Asset Management and Capital Risk

The 2024/25 Capital Finance Plan forecast a balanced capital budget and the unaudited figures for the year confirm a balanced position against a final Capital Resource Limit (CRL) of £12.8 million. The core capital allocation is separate from the Business Continuity Plan (BCP) funding discussed below.

DL (2024) 02, issued in February 2024, introduced a new approach to strategic infrastructure planning and investment across NHS Scotland. This required each NHS Board to prepare and submit to Scottish Government a Programme Initial Agreement setting out a deliverable, whole system service and infrastructure change plan for the next 20-30 years. The first planning phase was to develop a BCP, risk-assessed and based on the Board's existing infrastructure.

Following consideration by the SLT and the SPPRC, a BCP was approved for submission to Scottish Government by NHS Forth Valley's Board on 28 January 2025, meeting the 31 January submission deadline. The BCP totalled £8.6 million, later updated to £10.4 million per the approved Financial Plan, and contained 24 separate risk-assessed projects, two of which spanned more than one financial year.

The intention was that, following confirmation of funding by the Scottish Government, confirmed projects would be incorporated into the final version of the Financial Plan in March 2025. The financial plan to the NHS Forth Valley Board in March 2025 did reference the BCP but at that time "*SG have not confirmed whether the funding is likely to be available and we await formal feedback on our submission*".

The responsible officer has confirmed to Internal Audit that subsequent approval for two BCP projects was received, and meetings with Scottish Government colleagues took place in early May 2025 to discuss next steps and potential funding opportunities for specific streams and low-value items. Approval of funding is outwith NHS Forth Valley's direct control and receiving approvals in a staggered fashion brings challenges for the Board in effectively managing capital investment and risk.

The Estates and Supporting Infrastructure strategic risk SRR010 has remained static. The emerging outcome of the BCP submission will direct the mitigation of this risk. The April 2025 strategic risk update to the SPPRC noted that work has been paused on development of a Whole System Infrastructure Plan as the Board awaits specific guidance from Scottish Government on how to create this plan. A meeting in April 2025 called by the Scottish Government could lead to the provision of further detail. The Board needs to carefully manage the impact of reduced capital funding and the consequences therefrom including ensuring that the risk score reflects current and emerging pressures.

The core capital formula allocation going forward into 2025/26 (£6.7 million) is expected to be supplemented by income from property sales (£1.5 million) and the return of banked monies linked to slippage on various projects from prior years (£0.86 million). The return of banked monies and property proceeds comprise 26% of the total planned capital funding, but it is by no means certain that this will be received, the latest information from management is that property sales will likely not be concluded in 2025/26. The core capital formula allocation of £6.7 million is very small in comparison with the estimated Revenue Resource Limit (£977.5 million in 2025/26) and therefore the strategic risk needs to be carefully managed.

Climate Emergency & Net Zero Requirements

The NHS Forth Valley Annual Climate Emergency & Sustainability Report 2023/24 was approved by the NHS Forth Valley Climate Emergency & Sustainability Board and concluded that *"NHS Forth Valley is still making progress against the revised DL (2021) 38 baseline". "The process to shift onto a net-zero trajectory is underway at NHS Forth Valley and the DL38 targets have been adopted at Board level. Nevertheless, the current financial constraints will affect the Board's ability to respond to the climate emergency. Installation of renewable and decarbonisation technologies has been challenging as NHS Forth Valley's capital budget is fully utilised every year and prioritisation is given to essential maintenance, refurbishments and upgrades required to support safe service delivery".*

The Environmental Sustainability and Climate Change strategic risk SRR017 has remained high (20) throughout 2024/25 and is regularly reviewed, with a focused review taking place in August 2024. The Board awaits further Scottish Government input on the Business Continuity Plan submission, which impacts on and will inform further sustainability mitigations. In the interim, monies have been identified within the Capital Plan to support further initiatives, but this funding is assessed as not sufficient to allow NHS Forth Valley to meet the Scottish Government net-zero targets.

Resourcing to effectively implement the requirements of the Climate Emergency and Sustainability Strategy 2022-2026 continues to be a significant cost pressure and securing revenue funding to build a team is noted as a key financial challenge. Some progress has been made in that two members of the team are now certified trained auditors to progress implementation of the Environmental Management System, with NHS Assure supporting Boards to implement a Once for Scotland approach to this. Additionally, funding has been sourced for a Waste and Compliance Support Officer with recruitment to commence in 2025/26.

Digital and Information Governance

Strategic Risks:

Risk SRR003 – Information Governance – High Risk 12; Target 8 Medium

If NHS Forth Valley fails to implement and embed effective and consistent Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.

Risk SRR011 – Digital & eHealth - Infrastructure and Strategy – High Risk 20; Target 6 Medium

If NHS FV does not develop and effectively implement a Digital and eHealth strategy, enabling transformation, improvement and minimising technical vulnerabilities, there is a risk that other key organisational strategies cannot fully deliver the intended benefits, or the IT infrastructure could fail, resulting in an impact on long-term sustainability of the organisation and efficient and effective service delivery.

Risk SRR015 – Cyber Resilience – Very High Risk 20; Target 16 High

If NHS Forth Valley do not maintain the effectiveness of current cyber security controls and implement improvements to security controls where possible. There is a risk that the cyber security of the organisation may be compromised resulting in a significant disruption to the services delivered by the organisation and an impact to the confidentiality, integrity, and availability of systems and data.

Governance Arrangements and Assurance Reporting

The Information Governance (IG) Annual Report 2024, presented to the February 2025 SPPRC, provided Reasonable Assurance. It did note a compliance gap in relation to Freedom of Information (FOI) requests, with the Scottish Information Commissioner moving the Board to a Level 3 intervention from Level 1 due to inability to maintain consistent performance and compliance. The Annual Report provided information on the FOI remediation work taking place and significant issues in relation to staff resources in 2024 which impacted on performance.

The number of FOI requests has steadily increased over recent years (2021 - 590; 2022 - 764; 2023 - 977; and 2024 - 1094). The 2024 IG Annual Report assessed non-compliance with FOI statutory deadlines as critical.

Following the meeting with the Scottish Information Commissioner on 19 March 2025 including the Chief Executive, the SIRO and the Head of IG, an update report to the April SPPRC noted assurance was provided to the Commissioner on the steps being taken to remedy performance and that the recruitment process for two full-time Information Rights Officers to supplement current resource is underway. It is anticipated this will lead to a significant improvement from the 39% of requests answered within time between January and March 2025. The Head of IG continues to meet with the Commissioner's Case Officer on a monthly basis and we would expect that the trajectory towards the 80% improvement would be reported to SPPRC.

The draft Performance & Resources Committee (P&RC) Annual Report 2024/25 (April 2024 -December 2024) and the draft SPPRC Annual Report 2024/25 (December 2024 – March 2025) were presented to the April 2025 SPPRC meeting for approval. These draft Annual Reports provided assurance that the Committees had fulfilled their remits and noted the comprehensive IG related reports and minutes presented.

The IG Annual Report covered the 2024 calendar year was presented to the February 2025 SPPRC. Therefore, IG assurances for the period January 2025 to March 2025 were not available to inform the SPPRC annual report.

The draft SPPRC Annual Report did not give assurance on the progress of the Digital Delivery Plan 2024/25. An update was scheduled for the February 2025 SPPRC but was not provided to the Committee.

Not all papers to the P&RC/SPPRC and IG Group were issued five working days in advance of all meetings in line with Terms of Reference, meaning there is a risk that members have insufficient time to effectively scrutinise the papers ahead of each meeting.

Digital and eHealth Strategy

The most recent update on the Digital and eHealth Delivery Plan 2024/25 was presented to the P&RC in October 2024. The February 2025 SPPRC scheduled update was not provided. The April 2025 SPPRC considered a Digital Delivery Plan 2025-2026, however this did not provide an outcome assessment against the 2024/25 Plan.

The April 2025 Digital & eHealth Programme Board received the Delivery Plan 2024/25 Quarter 4 report, which included the RAG status of the projects and updates against individual projects. Two national initiative projects were reported as being at risk of not being completed within overall project milestones (GP IT Systems Replacement and Replacement of Child Health Systems), with the delays being outwith NHS Forth Valley control. Seven were behind quarterly milestones but on track to be delivered within project timescales, 23 were progressing as planned and 17 were reported as complete, on-hold or with no activity planned for the quarter.

The Digital Delivery Plan 2025/26 prioritises NHS Forth Valley's agreed projects and initiatives for the year. The Plan is supported by a balanced budget with investment from capital and strategic funding sources. Risks to the delivery of the 2025/26 Plan are clearly documented, and resilience of key systems and networks is a key focus for 2025/26. Issues noted as affecting the plan are national project slippage and insufficient skilled workforce. Updates on the 2025/26 Plan to the SPPRC are planned for June and December 2025.

GP IT Reprovisioning

The February 2025 SPPRC received a 'GP IT Reprovisioning Update' paper advising that NHS Forth Valley continued to prepare the rollout of the GP IT Reprovisioning project. Contracts for the supply and support of GP Clinical Systems within Scotland are coming to end of life in summer 2026 and therefore required a replacement system. The SPPRC took Reasonable Assurance that Forth Valley continued to prepare for the rollout, where possible associated with the national solution.

The February 2025 report noted that Organisation Risk 09 – GP IT Reprovisioning Project has a score of 15 for this project and that given the complexities around national projects, progress of this project will be continuously monitored.

Risk Management

The three strategic risks relating to IG and digital and eHealth aligned to the P&RC/SPPRC were reviewed as part of the Strategic Risk Register Review submitted to meetings in 2024/25. The current and target risk scores remained static within the year.

The focused review of SRR011 – Digital & eHealth - Infrastructure and Strategy, presented to the SPPRC April 2025 recommended an increase in the risk score. The SPPRC agreed the increased risk score from 15 to 20 due to the current vulnerability of the cyber team, and the risk was now out with appetite and tolerance. Three of the nine controls were RAG assessed as Red. These related to cyber security; ICT Infrastructure upgrades; and Disaster Recovery and Business Continuity Plans. The focused review provided Reasonable Assurance, noting that whilst a number of controls are either partially effective or not effective at all, an action plan is in place and the Digital & eHealth Teams are actively working to increase the effectiveness of the related controls. Careful monitoring of progress with the implementation of the controls in this area will be required.

The February 2025 SPPRC received the Cyber Security & Controls focused review of SRR015 and Organisational Risk 36 Internal Cyber Controls which provided Reasonable Assurance. The report noted the imminent outcome of the NIS assessment, the increased risk potentially posed by the current fragile position of the Cyber and Information Security team resilience, and the analysis work to be undertaken in relation to NHS Forth Valley's threat landscape. The Director of Digital recommended that a further focussed review be brought back to the SPPRC in August 2025 to provide an updated assessment of the threat landscape and NHS Forth Valley's mitigations of risk. This was approved and we welcome this earlier than planned opportunity for the SPPRC to consider the cyber risk environment.

The focused risk review of SRR003 IG provided Reasonable Assurance to the SPPRC in February 2025. There were 13 identified mitigating controls, one RAG assessed as green, two yellow, seven amber and four red. The focussed review concluded that there is more to do before this strategic risk can be brought within Appetite, however it is currently being managed within NHS Forth Valley's agreed risk tolerance. Given the Scottish Information Commissioner moving the board to a Level 3 intervention a risk score of 12 may not sufficiently reflect the IG risk position. There are no overt references to FOI/EIR or the Level 3 intervention within risk SRR003.

Network and Information Systems (NIS) Regulations

NHS Forth Valley achieved a strong performance of 80% compliance with the NIS Regulation for the 2023/24 Audit. Two of three KPIs set out by the Scottish Health Competent Agency had been achieved and an Action Plan was being drafted to progress compliance with the remaining 126 controls, with efforts focused on achieving the final KPI.

The NIS 2024-25 Progress Review, issued March 2025,was presented to the SPPRC April 2025. 90% Compliance had been achieved and further work is required on Roles & Responsibilities, Admin Account Management and Business Continuity/Disaster Recovery Testing.

The continuing improvement against NIS compliance is encouraging, however, there may be a risk to sustaining progress reflecting on the SPPRC cover paper workforce commentary that '*There are significant workforce risks, relating to retention of staff, and the current grading of key roles*'.

Cyber Security Training

The Information Governance Annual Report 2024 noted that whilst compliance with the cyber security module improved by 14% in 2024 to 64% (50% in 2023), improving compliance levels for the mandatory cybersecurity modules on Turas remains an ongoing process. Efforts continue to focus on raising awareness and enhancing engagement with the module to achieve higher compliance rates. The update on completion of the training module to the IG Group in April 2025 noted that overall compliance was 67%.

Information Governance Incidents

The IG Annual Report 2024 stated that 70 incidents were notified to the Information Commissioners Office (ICO) in 2024 (59 in 2023). Of these 48 (69%) were reported within the timescales (71% in 2023), 11 were outwith timescales and 12 are under investigation.

The Annual Report also noted that during 2024, three data protection breaches involving NHS Forth Valley data were assessed to meet the threshold required to report to the UK ICO and to the NIS Competent Authority (one in 2023). These involved a data integrity issue relating to an auto translation functionality, a confidentiality concern created by a security incident experienced by a supplier (it was later confirmed that NHS Forth Valley data was not impacted), and a data integrity issue relating to an automated update to a field in Trakcare. The Report noted that all incidents have been resolved, and the appropriate security incident/breach policies and procedures were followed ensuring that the situation was responded to appropriately.

The IG Annual Report 2024 notes that compliance with the Safe Information Handling module remains static compared to the previous year (51%), noting that a programme of targeted work to improve compliance in 2025. The update on completion of the training module to the IG Group in April 2025 noted that overall compliance was 60%.

Information Governance Policies

The IG Annual Report 2024 noted key policies and procedures which had been reviewed and updated in 2024. As reported at the IG Group in April 2025 11 policies / procedures were within review date 10 policies / procedures were past their review date.

No.	Audit Finding	Assessment of Risk	Management Response / Action	Responsible Officer Action by date
14	**Information Governance Assurances for SPPRC Year End Assurance** The Information Governance Annual Report 2024 provided assurance for the calendar year 2024, therefore assurance on overall Information Governance covering the period January to March 2025 was not provided to the SPPRC. This means that the SPPRC annual report 2024/25 cannot conclude on adequacy and effectiveness of IG arrangements for the full financial year.	 **Moderate**	This finding appears to repeat the finding made in ICE Report 2023/24 (A08/24) (Action point 12), in that it raises a potential gap in relation to the data provided to Committee to inform its assurance assessment. As previously noted, Committee is assured around Information Governance risk throughout the year via regular and routine reporting mechanisms. The Information Governance Annual Report is scheduled for February and is presented at the same time as the review of the strategic risk SRR.003. This update provides assurance to the Committee about the assurance mechanisms in place and their relative effectiveness for managing the Information Governance risk, meaning that Committee will be reasonably informed to make an assessment of the assurance processes within NHS Forth Valley before the end of the financial year. As at any time of the year, should a significant risk or incident emerge which requires reporting to Committee outwith the normal cycle	**Head of Information Governance** **31 August 2025**

			of updates provided around information governance, an exception report can be provided. Following the recommendation made within the ICE Report 23/24, P&R Committee endorsed the above mechanisms for providing assurance. This finding can be taken to SPPRC at the Six month IG update in August to seek their view regarding the current reporting mechanisms and their adequacy for informing annual assurance.	
15	**Assurance on Digital & eHealth Delivery Plan 2024/25** The draft SPPRC Annual Report did not provide assurance on the progress of the Digital Delivery Plan 2024/25. An update on the Delivery Plan was scheduled for the February 2025 SPPRC, however this was not provided to the Committee. The April 2025 SPPRC considered a Digital Delivery Plan 2025-2026, however this did not provide an outcome assessment against the 2024/25 Plan.	 **Moderate**	The end of year delivery plan update for 2024/25 had not been finalised for the February and April meetings, however the report is now completed and will be presented to the next SPPRC meeting in June.	**Director of eHealth** **30 June 2025**
16	**SRR003 – Information Governance Risk Score** Given the Scottish Information Commissioner moving the Board to a Level 3 intervention and the compliance concerns, the risk score of 12 may not sufficiently reflect the IG risk position. There are no overt references to FOI/EIR or the Level 3 intervention within risk SRR003.	 **Moderate**	The Head of Information Governance will meet with the Head of Risk Management to review SRR003 in light of the Level 3 intervention.	**Head of Information Governance** **31 August 2025**

	Performance Indicator	Target	2024/25	2023/24
1	Strategic/Annual Plan presented to Audit & Risk Committee by 30 June	**June**	No Oct 2025	Yes
2	Annual Internal Audit Report presented to Audit & Committee by 30 June	**June**	Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	**75%**	75%	100%
4	Draft reports issued by target date	**75%**	82%	83%
5	Responses received from client within timescale defined in reporting protocol	**75%**	100%	83%
6	Final reports presented to target Audit &Risk Committee	**75%**	85%	57%
7	Number of days delivered against plan	**100%**	100%	110%
8	Number of audits delivered to planned number of days (within 10%)	**75%**	42%	50%
9	Qualified skill mix	**50%**	54%	57%
10	Quality Questionnaire outcomes	**Average score of 3 or above**	3.1	3.1
11	Quality Questionnaire – percentage returned	**75%**	100%	N/A
12	Annual Quality Questionnaire completed by Chair of Audit & Risk Committee (score range 1 – 4)	**Average score of 3 or above**	To be completed after year end	N/A

	Performance Indicator	Target	2024/25	2023/24
13	Percentage of Internal Audit recommendations agreed with management	**75%**	100%	N/A
14	Percentage of action plans followed up	**90%**	100%	N/A
15	Number of training days per staff member	**Five days per annum**	7.6 days	N/A
16	Number of meetings with Chief Executive and Director of Finance per year	**Six**	Seven	N/A
17	Number of Audit & Risk Committee private sessions per year	**Two**	None	N/A

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	**None**
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	**Five**
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	**Ten**
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	**One**

ICE Report 2024/25 (A10/25) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. SPPRC Assessment a. The SPPRC Planner will map across work previously undertaken by the P&RC and include any additions e.g., Population Health. A read across will be undertaken to ensure no duplication with other Assurance Committees. **Acting Director of Strategic Planning & Performance, Board Secretary** **March 2025**	The SPPRC Planner drafted in line with the approved SPPRC ToR. The work previously considered by the P&RC has been included where relevant and any additional responsibilities of the SPPRC have been added. The Planner was presented to the SPPRC at its meeting in February 2025 for approval. Agenda setting meetings are in place for NHS Board and assurance committees with Board and SPPRC planners and agendas considered together at SPPRC agenda setting meeting and Board agenda setting meeting to ensure relevant read across.	 Complete
1. SPPRC Assessment b. The SPPRC planner under development will reflect the frequency of items of business noting that some may be reduced in frequency if appropriate. A SLT and Board workplan are currently being drafted to ensure alignment. **Acting Director of Strategic Planning & Performance, Board Secretary** **March 2025**	The SPPRC Planner details the frequency of items to be discussed however this may be amended throughout the year depending on requested follow up from Committee. The Board Planner has been drafted and will be presented to the NHS Board at its meeting in March 2025.	 Complete
1. SPPRC Assessment c. As part of the year end committee assurances, an assessment will be undertaken to ensure the intended benefits from the creation of the SPPRC have been achieved. **Acting Director of Strategic Planning & Performance, Board Secretary** **May 2025**	A Board Seminar was held in April 2025 to discuss progress around Culture, Leadership and Governance. Feedback was taken from the SPPRC members around how the SPPRC was functioning and if the desired outcome in terms of ensuring a space for strategic thinking was being achieved. At this time, the feedback was overwhelmingly positive in terms of providing the membership with the opportunity to shape and influence strategy development. It was noted that agendas were very full however, it was acknowledged that only 3 SPPRC meetings have taken place – December 2024, February 2025, April 2025 – with the meeting structure continuing to evolve. It was	 Complete

	highlighted that there was an improved alignment with and flow into the NHS Board. Relevant adjustments have been made to the Scheme of Delegation to align with the SPPRC Terms of Reference.	
2. Levels of Assurance The Board paper template is currently being reviewed by the Chair and Board Secretary. At a Board Development session on Active Governance held in December, there was a discussion around levels of assurance and a suggestion that assurance was binary; the Board or Committee members are either assured or not assured. Going forward this section may not be included in the papers with the risk section becoming more prominent and the recommendations more explicit. If the Assurance section remains in the Board and Assurance Committee paper template the level of Assurance will be captured in the Board minute. **Board Secretary** **March 2025**	The March Board will see the removal of the levels of assurance section of the Board and Governance Committee paper template. The May 2025 Board Action Log notes development of the Board Paper Template is ongoing with the Board Chair and appropriate officers and will include the role of the EQIA in Board reporting. The revised Board Paper Template will be implemented at the July 2025 meeting of the Forth Valley NHS Board and at future meetings of all Assurance Committees.	 Slippage
3. Performance Reporting Delivery Plan reporting for 2025/26 will be included as part of the Performance Report and will be aligned to Scottish Government timescales. **Acting Director of Strategic Planning and Performance** **September 2025**	The Delivery Plan was submitted to Scottish Government (SG) colleagues on 17 March 2025 in line with the guidance received. Following receipt of feedback from SG the Delivery Plan will be presented to the NHS Board for final approval in July 2025. Reporting guidance has not yet been received however reporting will be to the SPPRC in line with SG requirements.	 On track
4. Risk Management The process of reviewing and applying risk appetite is integral to the risk framework within NHS Forth Valley. When the risk appetite statements were set and agreed in July 2023, a formal review was due to be submitted to NHS Forth Valley Board in July 2024. However, due to national	Board Seminar planned for October2025. Revision to target date as the appetite statements will be submitted to Board for approval in November 2025.	 On track

improvements to the risk assessment matrix, this review was delayed, as both documents are significantly linked. It has been agreed that a review of the risk appetite statements will be conducted in the summer for subsequent approval at the Board. **Corporate Risk Manager** ~~**October 2025**~~ **November 2025**		
5. Escalation of No and Limited Assurance reports A further assurance paper from CGWG to CGC has already been trialled and will cover these points, in addition to other assurance information. **Head of Clinical Governance** **February 2025**	Assurance paper taken to CGC as part of CGWG update 11March 2025. Amendment made to action log for CGWG to highlight all No assurance or Limited assurance papers. CGWG update to CGC now includes section on No assurance or Limited assurance papers. The 2024/25 annual report for CGC included relevant update assurance papers within it.	 Complete
6. Clinical Policies and Procedures Clinical and Non Clinical Policies have been scheduled on the SLT Planner bi-monthly to ensure senior leadership oversight. The work on clinical policies will report to the CGWG at the April meeting, and then to subsequent CGC as appropriate. **Director of Pharmacy** **April 2025**	Clinical and non-clinical policies have been included on the SLT Planner for financial year 2025/2026 as a bi-monthly update along with audit action follow up. A paper was presented to CGWG April 2025 on the current action plan for the Clinical Policies which was endorsed by this group.	 Complete
7. SRR002 – Urgent and Unscheduled Care The risk is reviewed regularly by the Unscheduled Care Programme Board, with work led by the Corporate Risk Manager. It has been static for several years. The frequency of updates is guided by the relevant committee and the	The Urgent and Unscheduled Care risk update was scheduled for the SPPRC June 2025. At the SPPRC April 2025 meeting it was agreed that this risk would be realigned to the CGC due to the risk of patient harm.	 On track

Corporate Risk Manager. There has been no request for more frequent updates. The risk has now been aligned with the SPPRC. A focused review will be undertaken in June 2025 however the challenges around urgent and unscheduled care performance along with an update on progress against agreed actions will be presented to SPPRC regularly, per the Committee Planner. **Corporate Risk Manager** **June 2025**		
8. Workforce Planning Following the focused review of this risk at SGC in December 2024, the actions agreed will be prioritised and will be progressed to ensure workforce planning ownership and processes are improved to support the ambitions of service transformation. The initial focus will be on liaising with service leads across the organisation to inform the completion of the Scottish Government workforce plan return required by March 2025. Thereafter realignment of workforce planning functional leadership will build on organisational work to strengthen our staffing establishment control and enhance transformational change. The commencement of quarterly reporting will be in the SGC meeting schedule for 2025/26. **Director of People** ~~**May 2025**~~ **July 2025**	Initial work was scheduled to report to SGC in May in relation to changes to workforce planning governance and processes. To align with a more comprehensive review of programme governance within NHS Forth Valley, proposals have been re-scheduled to July 2025.	 Slippage
9. Governance Improvements All recommendations are accepted for implementation within our 2025/26 performance year cycle. Guidance will be provided to Staff Governance Committee paper authors to make specific reference to the appropriate Staff	From May 2025, Staff Governance Committee papers reference the relevant Staff Governance Standard within the Executive Summary of papers being brought forward to Committee.	 Complete

Governance Standard strand. Internal Audit Action follow up papers will have prioritisation of actions outlined within the paper. The Remuneration Committee Terms of Reference is scheduled for update and approval by the Board in March 2025 as part of the refresh of all governance committee Terms of Refences. **Director of People** **May 2025**	Updated Remuneration Committee Terms of Reference on the agenda of the 13 May SCG to be endorsed and recommended to the NHS Board for final approval.	
10. Focused Risk Review The focused review of financial sustainability risk will continue to be carried out annually within each financial year. The 2024/25 update will be presented at the SPPRC on 25 February 2025, aligned to the paper on draft Financial Plan which will be presented at the same meeting. **Director of Finance / Corporate Risk Manager** **February 2025**	Focused Review presented to SPPRC on the 25 February 2025.	 Complete
11. Financial Sustainability Actions to support delivery of long-term financial balance will be factored into the updated 3 year financial plan, aligned to the review of services as part of the Value Based Health and Care action plan. **Director of Finance** **March 2025**	The three-year financial plan, incorporating longer term savings plans associated with Value Based Health &Care, has been approved by NHS Board and Scottish Government.	 Complete

Annual Report 2023/24 (A06/25) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Assurance Committee Annual Report Standardisation A benchmarking exercise will be undertaken to review the Assurance Committee Annual Report templates utilised by other NHS Boards. A revised template will be drafted and circulated to Assurance Committee leads. **Head of Corporate Governance** **December 2024**	In conjunction with the Board Chair a review of the Annual Report Template has been conducted. Assurance Committee Annual Reports from previous years were looked at to identify where inconsistencies had arisen. Annual Reports from a number of other Boards were considered and compared to our local exemplar format (Performance & Resources Committee). NHS Forth Valley will use the template adapted for the Performance & Resources Committee in March 2024. This will be circulated to Assurance Committee Executive Leads and Administrative Support.	 Complete
2. Quality Strategy Reporting The Quality Strategy Implementation Report will be presented to CGC in July 2024 and will provide Reasonable Assurance. Implementation reports will be presented annually, until the end of life of the Strategy. **Head of Efficiency, Improvement, and Innovation** **June 2024**	The Quality Strategy Implementation Report was presented to CGC in July 2024 and provided Reasonable Assurance.	 Completed
3. Clinical Policy and Guidelines The clinical policy position will be reviewed with the Risk team to determine the level of organisational risk. The CGWG has identified the need to improve the policy review process and accountability in its action log and expects to see improvements demonstrated through the assurance reports it receives. **Head of Clinical Governance & Corporate Risk Manager** ~~**December 2024**~~	A paper on the clinical policies was presented to the Clinical Governance Working Group on the 7th of April 2025 highlighting the action plan being progressed to improve this position. This action plan was endorsed by them and will be tracked against the organisational risk for this.	 Complete

December 2025		
4. Assurance Levels Reported to the CGC Assurance mechanisms will be revised to reflect the status of the [Complaints and Feedback] performance and the actions being taken to mitigate risk. **Executive Nurse Director** **August 2024**	Reasonable Assurance is still being provided for Person Centred Care Reports, although performance issues are clearly identified in the cover papers. Minutes of CGC July 2024 noted limited assurance on stage 2 performance issues. For the Person Centred Care Report to CGC November 2024 Reasonable Assurance was provided with the cover paper summary noting that current performance needs to be significantly improved.	 Complete
5. Plan to Address Improvement Actions The Staff Governance Committee reporting will be reviewed as part of our ongoing improvement work. The reporting to Committee is being adjusted and this will be developed over the 2024/25 performance year to ensure that the Assurance Report for this year reflects the audit recommendations. **Director of Human Resources** **May 2025**	Committee reporting changes adopted and subject to approval of the Staff Governance Committee Annual Report 2024/25 this would support closure of the action.	 Complete
6. Staff Governance Committee Workplan The Director of HR will work with the Head of Corporate Governance and Board Secretary to ensure the Staff Governance Committee Workplan reporting is consistent with all other Governance Committees in providing clear and transparent updates to the Staff Governance Committee. It is noted that our current Workplan format is consistent with other committees so unless there are changes proposed across all governance committees, it is proposed the point raised will be reflected in the Workplan cover paper. **Director of Human Resources**	Workplan adjustments have been made and reporting updated to reflect rationale for any change being explicitly advised to Committee.	 Complete

September 2024		
7. Remuneration Committee Reporting An Annual Assurance Report for 2023/24 will be presented the next Remuneration Committee and reported to the Staff Governance Committee in line with existing governance practice. Any further changes to governance practice will be considered following review of current sector practice, noting that variations across Boards is a known national issue and we will respond as necessary to any further national direction. **Director of Human Resources** **September 2024**	Remuneration Committee Annual Report was approved at July 2024 Staff Governance Committee.	 Complete
8. Risk Reporting The focused review of Primary Care Sustainability will be completed at the June 2024 Staff Governance Committee (SGC). A dedicated SGC session is being planned before our next scheduled meeting in September and this will inform our strategic planning. **Director of Human Resources** ~~**September 2024**~~ **December 2024**	All Strategic Workforce risks have had a Focused Review conducted during the Staff Governance Committee 2024/25 cycle with future reporting built into the Committee workplan for next year.	 Complete
9. Financial Risk The strategic risk on financial sustainability will be updated to reflect new and emerging risks, including those outlined in the financial plan, as part of the next routine quarterly update to the strategic risk register. **Director of Finance** **September 2024**	Following discussion with the Corporate Risk Manager and Director of Finance, the risks highlighted in the approved Financial Plan for 24/25 have been referenced as risk factors within the Financial Sustainability Strategic Risk. We have met the requirement as we have ensured that there is a read across between the financial plan and the associated strategic risk.	 Complete

10. Presentation of Full Year Results Going forward a table will be included in the year-end outturn report to illustrate key movements in the final outturn position compared to the original financial plan projection. **Deputy Director of Finance** **March 2025**	Table included in Month 12 finance report.	 Completed

ICE Report 2023/24 (A08/24) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Firebreak Learning An action plan has been developed incorporating actions informed by the Firebreak, business as usual (BAU) and the work with the Centre for Sustainable Delivery. A measurement programme has been developed with key owners and timescales. Actions will be taken forward with the intention that these become BAU over time. Regular performance updates against the agreed actions / measures will be reported through the relevant Assurance Committee. **Director of Acute Services** **December 2024**	All learning and cross reference to workstreams like the Firebreak, Centre for Sustainable Delivery review and Healthcare Improvement Scotland inspections have been undertaken and collated into the Urgent and Unscheduled Care action plan which is now enacted. Update provided to NHS Forth Valley Board November 2024 and P&RC October 2024 with Urgent & Unscheduled Care Update report.	 Complete
2. Triggers for Deep Dives An annual programme of Strategic Risk focused reviews will continue to be developed into 2024/2025. These will be detailed within Assurance Committee planners. A full focused review of each Strategic Risk will be undertaken annually with a progress update on actions identified to enhance the control environment brought back to the relevant Assurance Committee throughout the year. In addition, the schedule of focused review will be kept under review. **Head of Policy and Performance** **March 2024**	Schedule of Strategic Risk Focused Reviews for 2024/2025 agreed and shared with Assurance Committee Executive leads and admin support for inclusion in committee planners. All current strategic risks included.	 Complete
3. Partner Risk Registers	Initial meeting held 16 August 2024. Next meeting scheduled for January 2025 where draft terms of	

Work is currently progressing around the review and alignment of all partners Strategic Risk Registers which will include creating a process to enhance the flow of risk information. The Corporate Risk Team work closely with the IJBs to review and update all relevant risks ensuring appropriate information is considered. This is part of a wider piece of work ongoing to enhance the risk management framework between partner organisations. This work will link to the review of integration schemes being undertaken by the four Chief Executives. **Head of Policy and Performance** ~~**June 2024**~~ **December 2025**	reference will be considered. The initial scope of the group is to share risk registers and see where specific bits of comparison should be picked up. Revised target date December 2025 to progress formal structure.	 Slippage
4. CGC Assurances The Head of Clinical Governance, Medical Director, and Chair of the CGC will put in place a process to ensure that any gaps in presentation of reports scheduled on the forward planner will be highlighted. This will commence after the CGC meeting has taken place in January and will therefore be visible in the committee planner from the CGC meeting in in March 2024 onwards. **Medical Director and Head of Clinical Governance** **March 2024**	Forward planner presented to each CGC meeting, where Chair asks Head of Clinical Governance to confirm if there are any planner items which have not been tabled. Internal audit report A08/24 ICE was presented to the March 2024 CGC.	 Complete
5. Clinical and Care Assurance The reporting to the CGWG and the CGC is being revised to include wider system assurance reports from both partnerships through their professional leads to obtain assurance on the quality of care. Both partnerships are also reviewing their Integration Schemes and, as part of that process, there is an opportunity to include clear C&CG arrangements.	Whole System Assurance Report template now in place and presented to each meeting of the CGWG and CGC.	 Complete

The first new assurance report will be presented to CGWG on 8 February 2024 and to CGC in March 2024. **Medical Director** **July 2024**		
6. Significant Adverse Event Reporting The Head of Clinical Governance is currently working with the Medical Director, Clinical Governance Managers, and colleagues in other Health boards to identify the best examples of demonstrating the KPIs. This work will be shared with the CGC members to ensure that the agreed format represents the KPI information to help support our clinical governance assurance process in relation to SAERs. **Medical Director and Head of Clinical Governance** **July 2024**	Revision to SAER reporting to CGC undertaken with used of data and graphical presentation. KPIs performance clearly highlighted at start of the report. Further review of report format was also undertaken with learning and action themes now included.	 Complete
7. Safety and Assurance Reporting The Safety and Assurance Report is currently under review. The SPSP focused section of the report will be managed by the Acute Directorate Clinical Governance leads. There are two Acute Directorate Clinical Governance events planned in February and March where much of the discussion around safety metrics, measurement, monitoring, and assurance will take place. The Directorate Assurance aspect of the report will be separated and will have specific assurance metrics to provide assurance to the CGWG and CGC on areas of clinical governance e.g., regular meetings, SAERs, Risks, Clinical Guidelines etc. **Medical Director and Head of Clinical Governance** **July 2024**	The Acute Safety and Assurance Report is in place and presented to each meeting of the CGWG and CGC. Report includes measures and metrics and action tables for each safety topic.	 Complete

8. Patient Experience A detailed assessment of current performance and the operational risks related to poor performance were outlined for the CGC in January 2024 with an action plan presented in terms of mitigation steps to be taken. The current backlog has been recognised as a formal organisational risk; the risk is being further developed for formal reporting on the corporate risk register. Action plan to be updated within the Person Centred Complaints and Feedback Report at each meeting of the Clinical Governance Committee highlighting progress against actions, barriers and risks, and any mitigating actions required. **Head of Person Centred Care** **March 2024**	Details provided to CGC with a detailed action plan and recognition of current position. Mitigation steps in place including changes in process, additional non-recurrent staffing, and further improvements in scope. In tandem with the National Centre for Excellence in Artificial Intelligence, we are looking towards automation and adopting AI methods to further reduce the backlog in a sustainable way. Management have advised they are able to demonstrate a 27% increase in productivity / capacity within the patient relations department over the last quarter. The average time to respond has reduced from 80 days to 55 days with a continued focus to further reduce. Awareness days have been completed within the acute sector with further dedicated drop offs to be planned. Quarterly learning bulletin has been developed with key learning summaries. Management have noted although reporting mechanisms are in place, the risk of the current backlog continues following an increase in the volume of complaints.	 Complete
9. Workforce Strategy and Plan The People Strategy will be developed as a key enabler for our Healthcare Strategy. In the meantime, we will develop our Workforce Planning update reporting to assure the Staff Governance Committee and will consider how best to triangulate the information with resourcing update reports as indicated in the recommendation. **Director of Human Resources** ~~**May 2024**~~ **March 2025**	Work completed subject to approval of the Scottish Government Workforce Planning return. Workforce Plan 2025 presented to the SGC March 2025 which endorsed the submission to Scottish Government.	 Complete

10. Performance Reporting The work on Workforce Performance Reporting through the Pentana system will support our ability to refine the performance reporting to support the proposed enhancement. **Director of Human Resources** ~~**March 2024**~~ **May 2025**	The completion of performance reporting changes included within the Staff Governance report as per the recommendation has been completed.	 Complete
11. Remuneration Committee The completion of a Remuneration Committee self-assessment will be built into the workplan for 2024/25. Paper issue timescales have been improved from the last meeting in December 2023, and it has been agreed with the Committee that this work will be further strengthened through scheduling key activities to align with the Committee meeting cycle. **Director of Human Resources** ~~**December 2024**~~ **March 2025**	Assessment of Remuneration Committee operation has been completed noting the agreement of our performance schedule of 2025/26 and the update of the Committee Terms of Reference which went to SGC May 2025.	 Complete
12. Information Governance Annual Assurances P&RC is assured around Information Governance risk throughout the year via regular and routine reporting mechanisms. The Information Governance Annual Report is scheduled for the P&RC in February 2024, and it has been agreed that this update will coincide with future reviews of the strategic risk SRR.003. This update provides assurance to the Committee about the assurance mechanisms in place and their relative effectiveness for managing the Information Governance risk, meaning that they will be reasonably informed to make an assessment of the assurance processes within NHS Forth Valley ahead of the	The Information Governance Annual Report 2023 went to the February 2024 P&RC, where the assurance activity and level of assurance was noted. The meeting also noted the future reviews of the strategic risk SRR.003 Information Governance focused risk review and endorsed the actions identified to further manage the risk into appetite, as well as the level of assurance provided.	 Complete

April meeting which will receive the P&RC Draft Annual Report. The Information Governance Group meetings have been scheduled to ensure they take place ahead of the P&R and so IGG minutes, with a highlight report, will be available to the P&R meeting in April. This will enable emerging risks or incidents to be highlighted as required. As at any time of the year, should a significant risk or incident emerge which requires reporting to Committee outwith the normal cycle of updates provided around information governance, an exception report can be provided, as was done in relation to the Adastra incident. It is considered that the existing agreed reporting mechanisms are adequate to inform the Committee Annual Assurance Statement. **Head of Information Governance** **Complete**		